

ID #: \_\_\_\_\_  
(Internal Use Only)

# QUINTILES STUDY PARTICIPATION APPLICATION

Date Rcvd: \_\_\_\_\_  
(Internal Use Only)

## Your Primary Information

Mr.  Ms.  Mrs.  Miss                      Gender  Male  Female  
 First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ Known As: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Previous Name: \_\_\_\_\_  
 Current Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

## Your Next of Kin / Emergency Contact

Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## Your Basic Information

Race:  American Indian or Alaska Native     Asian     Black                      Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
            Native Hawaiian or Pacific Islander     White  
 Do you drink alcohol?     Yes     No                      If yes, number of drinks per week: \_\_\_\_\_  
 Tobacco Use:     Never Smoked     Former Smoker     Current Smoker    Date Last Smoked: \_\_\_\_\_ Amount: \_\_\_\_\_  
 Study Availability:  1-3 Days     3-10 Days                       10 + Days                       Outpatient                       Weekends  
 Ethnicity:     Hispanic or Latino                       Not Hispanic or Latino  
 Date of last Blood Donation: \_\_\_\_\_                      Date of last Plasma Donation: \_\_\_\_\_  
 Special Dietary Requirements (*vegetarian/lactose/etc.*): \_\_\_\_\_                      Total Caffeine Drinks per day: \_\_\_\_\_  
 When was the last date that you used illicit drugs? (*Marijuana, cocaine, crack, etc.*)                      Date of last use: \_\_\_\_\_  
 Do you have any history of drug or alcohol problems / treatment?                       Yes     No                      Date of treatment: \_\_\_\_\_

## Female Only

Are you of child bearing potential?                       Yes     No                      Date of last menstruation: \_\_\_\_\_  
 Method of birth control: \_\_\_\_\_                      Start Date: \_\_\_\_\_                      Date of last Pap Smear: \_\_\_\_\_  
 Secondary birth control: \_\_\_\_\_                      Partner's birth control: \_\_\_\_\_

## How did you hear about Quintiles? (Insert information on only the one that prompted you to fill out this application)

Personal referral:                      Name: \_\_\_\_\_                      Internet / Email: \_\_\_\_\_  
 Television / Video: \_\_\_\_\_                      Radio Station: \_\_\_\_\_  
 Newspaper or Publication: \_\_\_\_\_  
 Outreach Event (Please indicate event and approximate date): \_\_\_\_\_

Are you taking or have ever taken over-the-counter or prescription medications?     Yes     No    If yes, please list below:

| Name of Medication | How Much | How Often | Reason for Taking | Start Date | Stop Date |
|--------------------|----------|-----------|-------------------|------------|-----------|
|                    |          |           |                   |            |           |
|                    |          |           |                   |            |           |
|                    |          |           |                   |            |           |
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|                    |          |           |                   |            |           |

**Quintiles Address:** 6700 W. 115th Street, Overland Park, KS 66211

**Phone:** 913-894-5533 or 1-800-292-5533    **Fax:** 913-708-7608

**Email:** [volunteer@quintiles.com](mailto:volunteer@quintiles.com)    **Website:** [www.studyforchange.com](http://www.studyforchange.com)

Please mark "X" in each (  ) any condition for which you have ever been **diagnosed** or **treated** by a **physician**. Next to each "X", list the **date (mm/dd/yyyy) the condition began** and provide specific details at the bottom of the page.

**ALLERGIES**

- Environment  \_\_\_\_\_
- Food  \_\_\_\_\_
- Medications  \_\_\_\_\_
- Animals  \_\_\_\_\_
- Other  \_\_\_\_\_

**MEDICATIONS**

- Over-the-counter  \_\_\_\_\_
- Over-the-counter  \_\_\_\_\_
- Over-the-counter  \_\_\_\_\_
- Over-the-counter  \_\_\_\_\_
- Prescription  \_\_\_\_\_
- Prescription  \_\_\_\_\_
- Prescription  \_\_\_\_\_
- Prescription  \_\_\_\_\_
- Birth Control / HRT  \_\_\_\_\_
- Other  \_\_\_\_\_

**AUDITORY SYSTEM**

- Dizziness  \_\_\_\_\_
- Hearing Loss  \_\_\_\_\_
- Other  \_\_\_\_\_

**CANCER**

- Cervical  \_\_\_\_\_
- Basal / Skin  \_\_\_\_\_
- Other  \_\_\_\_\_

**CARDIOVASCULAR**

- Abnormal ECG  \_\_\_\_\_
- Angina  \_\_\_\_\_
- Congest. Heart Failure  \_\_\_\_\_
- Coronary Artery Disease  \_\_\_\_\_
- Heart Attack  \_\_\_\_\_
- High Blood Pressure  \_\_\_\_\_
- High Cholesterol  \_\_\_\_\_
- Palpitations  \_\_\_\_\_
- Pericarditis  \_\_\_\_\_
- Stroke  \_\_\_\_\_
- Other  \_\_\_\_\_

**ENDOCRINE**

- Hyperthyroidism  \_\_\_\_\_
- Hypothyroidism  \_\_\_\_\_
- Obesity  \_\_\_\_\_
- Other  \_\_\_\_\_

**DIABETES**

- Diabetes  \_\_\_\_\_
- Other  \_\_\_\_\_

**EYE**

- Color Blind  \_\_\_\_\_
- Blind  \_\_\_\_\_
- Cataract  \_\_\_\_\_
- Glasses or Contacts  \_\_\_\_\_

**EYE (continued)**

- Glaucoma  \_\_\_\_\_
- Laser Surgery  \_\_\_\_\_
- Pterygium  \_\_\_\_\_
- Other  \_\_\_\_\_

**GASTROINTESTINAL**

- Acid Reflux  \_\_\_\_\_
- GERD  \_\_\_\_\_
- Colitis  \_\_\_\_\_
- Gall Bladder Disorder  \_\_\_\_\_
- Hernia  \_\_\_\_\_
- Irritable Bowel Synd  \_\_\_\_\_
- Liver Disorders  \_\_\_\_\_
- Ulcer  \_\_\_\_\_
- Unusual Constipation  \_\_\_\_\_
- Unusual Diarrhea  \_\_\_\_\_
- Other  \_\_\_\_\_

**HEMATOLOGIC**

- Poor or Small Veins  \_\_\_\_\_
- Anemia  \_\_\_\_\_
- Blood Clotting  \_\_\_\_\_
- Sickle Cell Trait  \_\_\_\_\_
- Thalassaemia Trait  \_\_\_\_\_
- Other  \_\_\_\_\_

**IMMUNE SYSTEM**

- Autoimmune Disease  \_\_\_\_\_
- Hepatitis A  \_\_\_\_\_
- Hepatitis B / C  \_\_\_\_\_
- HIV  \_\_\_\_\_
- Hep B Immunization  \_\_\_\_\_
- Other  \_\_\_\_\_

**METABOLISM**

- Metabolic Syndrome  \_\_\_\_\_
- Genetic Testing  \_\_\_\_\_
- Other  \_\_\_\_\_

**MUSCULOSKELETAL**

- Back Ache  \_\_\_\_\_
- Head Injury  \_\_\_\_\_
- Limb Fracture  \_\_\_\_\_
- Osteoarthritis  \_\_\_\_\_
- Osteoporosis  \_\_\_\_\_
- Rheum. Arthritis  \_\_\_\_\_
- Other  \_\_\_\_\_

**NERVOUS SYSTEM**

- Alzheimers  \_\_\_\_\_
- Febrile Convulsion  \_\_\_\_\_
- Frequent Headaches  \_\_\_\_\_
- Migraine  \_\_\_\_\_
- Multiple Sclerosis  \_\_\_\_\_
- Parkinsons  \_\_\_\_\_
- Seizure Disorders  \_\_\_\_\_
- Other  \_\_\_\_\_

**PSYCHOLOGICAL**

- ADD or ADHD  \_\_\_\_\_
- Addictive Disorders  \_\_\_\_\_
- Anxiety Disorders  \_\_\_\_\_
- Depression  \_\_\_\_\_
- Manic Depression  \_\_\_\_\_
- Memory Loss  \_\_\_\_\_
- Schizophrenia  \_\_\_\_\_
- Sleep Disorders  \_\_\_\_\_
- Other  \_\_\_\_\_

**REPRODUCTIVE - FEMALE ONLY**

- Endometriosis  \_\_\_\_\_
- Child Birth / Lactating  \_\_\_\_\_
- Vaginal Infections  \_\_\_\_\_
- Tubal Ligation  \_\_\_\_\_
- Hysterectomy  \_\_\_\_\_
- Post Menopausal  \_\_\_\_\_
- Other  \_\_\_\_\_

**REPRODUCTIVE - MALE ONLY**

- Impotence  \_\_\_\_\_
- Infertility  \_\_\_\_\_
- Testicular Torsion  \_\_\_\_\_
- Vasectomy  \_\_\_\_\_
- Undecended Teste  \_\_\_\_\_
- Other  \_\_\_\_\_

**RESPIRATORY**

- Asthma - Adult  \_\_\_\_\_
- Asthma - Childhood  \_\_\_\_\_
- Chronic Bronchitis  \_\_\_\_\_
- Emphysema  \_\_\_\_\_
- Hayfever / Sinus  \_\_\_\_\_
- Pneumonia  \_\_\_\_\_
- Pnuemothorax  \_\_\_\_\_
- Other  \_\_\_\_\_

**SKIN & SOFT TISSUE**

- Acne  \_\_\_\_\_
- Eczema  \_\_\_\_\_
- Hair Loss  \_\_\_\_\_
- Psoriasis  \_\_\_\_\_
- Other  \_\_\_\_\_

**URINARY**

- Kidney Infections  \_\_\_\_\_
- Kidney Stones  \_\_\_\_\_
- Kidney Abnormality  \_\_\_\_\_
- Other  \_\_\_\_\_

**SURGERY**

- Type of surgery  \_\_\_\_\_
- Type of surgery  \_\_\_\_\_
- Type of surgery  \_\_\_\_\_
- Type of surgery  \_\_\_\_\_
- Other  \_\_\_\_\_

For each category checked above, please provide the additional information below:

| DIAGNOSIS | DATE DIAGNOSED | TYPE OF TREATMENT RECEIVED | IS THE CONDITION STILL PRESENT? |
|-----------|----------------|----------------------------|---------------------------------|
|           |                |                            |                                 |
|           |                |                            |                                 |
|           |                |                            |                                 |

Have you ever been hospitalized, had emergency room treatment or any other medical problems?  Yes  No If so, please describe:

\_\_\_\_\_

