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Research Participant Medical Questionnaire

I. Personal Information

First Name: _____ Middle Name: _____

Last Name: _____

Home Street Address: _____

City, State, Zip: _____

Last 4-digits of SSN: _____ Date of Birth: _____

Gender: ❑ Male ❑ Female Age: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Other

Race: ❑ Caucasian ❑ Black ❑ Hispanic ❑ Asian ❑ Native American ❑ Pacific Islander

❑ Asian Pacific American ❑ Alaskan Native ❑ Black-Non Hispanic

❑ White-Non Hispanic ❑ Other (supply name) _____

Personal ph#: _____ Work ph# _____

Email Address: _____

Emergency Contact

First Name: _____ Personal ph#: _____

Last Name: _____ Work ph#: _____

*How are **you** related to the Emergency Contact?*

You are the: ❑ Spouse ❑ Parent ❑ Son/Daughter ❑ Grandchild ❑ Niece/Nephew ❑ Aunt/Uncle ❑ Employee

II. Personal Physician Contact Information

Do you have a personal physician: ❑ Yes ❑ No

Physician's Full Name _____

Do you have a nephrologist (kidney doctor) or cardiologist (heart doctor)? ❑ Yes ❑ No

Physician's Full Name _____

III. I attest that the personal and medical information provided is correct to the best of my knowledge.	
Participants Signature: **X**	Date:
Reviewed by Clinician's signature:	Date:

IV. Medical Information

In what research study are you participating?	❑ Salt Counseling ❑ Women's Skin Blood Flow ❑ Men's Skin Blood Flow ❑ Sympathetic Reactivity ❑ Potassium ❑ Dietary Counseling ❑ Exercise Training & CKD ❑ Mitochondria Health & CKD ❑ SBIR ❑ FFES ❑ Joint Replacement ❑ Healthy Heart & Mind ❑ STAR Quit ❑ Salt Study

Check any of the medical conditions listed that **you** have been diagnosed with:	❑ High Blood Pressure ❑ Heart Disease ❑ High Cholesterol ❑ Kidney Disease	❑ Asthma ❑ Emphysema ❑ Cancer ❑ Anemia	❑ Diabetes ❑ Stroke ❑ Blood Clots

List any other medical diagnosis you have:

Have you been hospitalized for any significant injury or illness: ❑ Yes ❑ No

If **yes** list reason and dates:

	F M	F M	F M
Check any of the medical conditions listed that either your **F**ather or **M**other have been diagnosed with:	❑ ❑ High Blood Pressure ❑ ❑ Heart Disease ❑ ❑ High Cholesterol ❑ ❑ Kidney Disease	❑ ❑ Asthma ❑ ❑ Emphysema ❑ ❑ Cancer ❑ ❑ Anemia	❑ ❑ Diabetes ❑ ❑ Stroke ❑ ❑ Blood Clots

If you are currently taking any prescription medicine, over-the-counter medicine, vitamins, herbs, nutritional supplements or birth control pills, please list the medication **name, dosage and frequency** taken below

1.	5.
2.	6.
3.	7.
4.	8.

Are you **ALLERGIC** to any medication, food or latex?	❑ Yes ❑ No	If yes what?	Type of reaction:
Do you smoke?	❑ Yes ❑ No	If yes how much?	How many years?
Did you ever smoke?	❑ Yes ❑ No	If yes, quit date?	# Yrs. smoked?
Do you drink alcohol?	❑ Yes ❑ No	If yes how much?	How many years?
Do you drink caffeinated drinks	❑ Yes ❑ No	If yes how much?	Type: ❑ Coffee ❑ Tea ❑ Soda
Do you normally eat a balanced diet	❑ Yes ❑ No	Meals per day?	Snacks per day?
Do you exercise on a regular basis?	❑ Yes ❑ No	Days per week?	Type of:

Have you had any of the following tests? If yes, include last year you had the test.

Year	Year	Year	Year

❑ EKG ❑ Stress Test ❑ Colonoscopy ❑ Mammogram

Check any symptoms and or conditions listed below that you have experienced in the **past 12 months**:

Vision:	❑ Change in far vision ❑ Change in near vision ❑ Blurred Vision
Hearing:	❑ Ear pain ❑ Loss of Hearing ❑ Ringing in Ears
Musculoskeletal	❑ Joint Pain ❑ Joint Stiffness ❑ Muscle weakness ❑ Unsteady Walking
Cardiovascular	❑ Chest pain ❑ Palpitations
Respiratory:	❑ Shortness of breath ❑ Wheezing ❑ Coughing ❑ Coughing up blood
Circulatory:	❑ Swelling of the Hands/Feet ❑ Leg Cramps with walking
Endocrine:	❑ Excessive thirst ❑ Frequent urination ❑ Unintentional Weight Change > 5 lb.
Gastrointestinal	❑ Diarrhea ❑ Constipation ❑ Blood in stools ❑ Heartburn
Neurological	❑ Headaches ❑ Numbness or tingling in extremities
Emotional:	❑ Depression ❑ Anxiety