Florida Institute for Clinical Research

Humberto Cruz, D.O.
Medical Director

Maria Lopez, CCRC
Research Director

Protocol #: _____ Subj. Initials ___ ___ ___ Subj. #_____

Visit Date ____/_____/____ **Version #5**

Please check box, or comment if not listed or if clarification necessary. **List the year of diagnoses next to each condition that applies to you.**

Medical History Form

Neurological System-

□Seizures_____ □ Dizziness_____ □ Numbness/Tingling in Arms/Legs_____
□Fainting Spells_____ □Stroke_____ □Headaches_____
□ Diabetic Peripheral Neuropathy_____

Eyes-

□Nearsighted_____ □Farsighted_____ □ Blurred Vision_____ □Glaucoma_____
□Cataracts_____ □Retinal Problems_____ □Blindness_____
□Reading Glasses_____

Ears-

□Ringing in Ears_____ □Hearing Loss_____ □Frequent Ear Infections_____
□ Increased Cerumen Production_____ □ Vertigo_____

Nose-

□Nasal Congestion_____ □Chronic Allergies_____ □ Sinus Trouble_____
□ Nose Bleeds_____ □ Post Nasal Drip_____ □ Deviated Septum_____
□ Nasal Polyps_____

Throat/Mouth-

□Trouble Swallowing_____ □Tonsillitis_____ □Dry Mouth_____
□Scratchy/Sore Throat_____ □Mouth Sores_____Tonsillectomy_____

Hematological/ Lymphatic-

□Blood Disorders_____ □Anemia_____ □Chronic Swollen Glands_____
□Bleeding Problem_____ □Blood Transfusions_____
□Enlarged Lymph Nodes_____

Respiratory-

□Asthma_____ □Emphysema_____ □Collapsed Lung_____
□Chronic Cough_____ □Tuberculosis_____ □Shortness of Breath_____
□Bronchitis_____ □Pneumonia_____ □COPD_____
□Coughing Blood or Phlegm_____

Cardiovascular-

□Chest Pain_____ □High Blood Pressure_____ □Heart Attack_____
□Arteriosclerosis_____ □ Irregular Heartbeats_____ □Slow Pulse_____
□Pace Maker_____ □ Blood Clots_____ □Varicose Veins_____
□Rheumatic Fever_____ □Telangiectasis_____ □High Cholesterol_____
□Mitral Value Prolapse_____

Other-

Explain:_____
_____

Coordinator Signature_____ Date _____

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Gastrointestinal-

□Stomach/Gastric/Duodenal Ulcer_____ □Hiatal Hernia_____
□Heartburn_____ □Nausea/Vomiting_____ □Reflux_____
□Abdominal Bloating/Cramps_____ □Constipation/Diarrhea_____
□Irritable Bowel Syndrome_____ □Gall-Bladder Problems or Stones_____
□Cholecystectomy_____ □Pancreas Problems_____Herniorrhaphy_____
□Ulcerative Colitis_____ □Hemorrhoids_____Appendectomy_____
□Diverticulosis/Diverticulitis_____ □G.I Bleeds □Spastic Colon_____

Hepatic-

□Cirrhosis_____ □Yellow Jaundice_____ □Hepatitis A or B or C_____
□History of Elevated Liver Function Tests_____

Endocrine/Metabolic-

□Hypoglycemia/Hyperglycemia_____ □Hyperthyroidism_____
□Hypothyroidism_____ □Diabetes_____

Renal/Genitourinary-

□Kidney Problems/Stones_____ □Frequent UTI's_____
□ Burning on Urination_____
IF FEMALE: LMP ___/____/___
□Premenopausal_____ □Postmenopausal_____ □Fibrocystic breast Disease_____□Fibroid Uterus_____□Ovarian Cyst_____ Tubal Ligation_____ Hysterectomy _____
Male or Female any problem with reproductive organs:
□Prostate Problems_____ □Hormone Disorder_____
□ Itching/Soreness/Redness Genital Area_____

Musculoskeletal-

□Muscle Problems_____ □Broken Bones_____ □Osteo or Rheumatoid_____
□Back Pain_____ □Leg Cramps_____ □Gout_____ □Tendonitis_____
□Bursitis_____ □Fibromyalgia_____

Dermatological-

□Eczema_____ □Shingles_____ □Hives_____ □Rashes_____ □Psoriasis_____ □Dry Skin_____ □Acne_____

Psychiatric-

□Anxiety_____ □Depression_____ □Fatigue_____ □Drowsiness_____
□Restlessness_____ □Insomnia _____ □ Bipolar _____
□Any Hospitalization for Psychiatric Illness_____

Coordinator Signature_____ Date _____

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Cancer
□History of Cancer **If Yes: When_____/_____ What Kind_____/_____**

Medical History Form (cont.)

Coordinator Signature_____ Date _____