

Volunteer Information & Medical History Form PLEASE PRINT

Social Security Number: \_\_\_\_\_

Mr.  Mrs.  Ms.  Other \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Initial

\_\_\_\_\_  
Address City State Zip Code

( ) ( )  
Daytime Telephone Evening Telephone Occupation

Education Level:  Grade School  High School  College  Post Grad  Other

Date of Birth	____/____/____ month day year	Age	_____
Sex:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	<input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> White
Height:	_____	Weight:	_____
		<input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Other	_____

SMOKING HISTORY			
Never Smoked	Previous Smoker, Quit: ____/____/____	Amount/Day	Yrs
	Current Smoker	Amount/Day	Yrs

ALCOHOL USE	
Amount of alcohol is defined as follows:	
12 oz. Regular or lite beer = 1 drink	4 oz. wine = 1 drink
2 oz. desert wine = 1 drink	1 oz. spirits = 1 drink
How many alcoholic beverages do you drink per week (average)? _____	

CURRENT SPECIAL DIETS FOLLOWED		
Diabetic	Low-fat/Low-cholesterol	Other: _____
Low-salt	Weight reduction	_____

Please fill in "DATE BEGUN", "DATE ENDED" and "CONDITION CONTINUES?" for all "YES" answers.

**CARDIOVASCULAR (Heart & Circulation)**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Blood Clots						
Hypertension (high blood pressure)						
MI (heart attack)						
Coronary (heart) Artery Disease						
Carotid Artery Disease (blocked neck arteries)						
Claudication (blocked leg arteries)						
Angina (chest pain)						
Arrhythmia (irregular heart beats)						
Palpitation						
Congestive Heart Failure (enlarged heart)						
Endocarditis (heart muscle inflammation)						
Peripheral Vascular Disease						
Leg-Swelling (Edema)						
Other (describe): _____						

**GASTROINTESTINAL (Stomach & Intestines)**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Esophageal Reflux						
Indigestion						
Diarrhea (frequent)						
Constipation (frequent)						
Hiatal Hernia						
Ulcer						
Gallbladder Disease						
Gallstones						
Diverticulitis/Diverticulosis (Polyps)						
Hemorrhoids						
Other (describe): _____						

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**MUSCULOSKELETAL (Muscles & Bones)**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Arthritis						
Back Problem (specify):						
Fractures, broken bones / specify which bones:						
Other (describe):						

**EYES**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Glasses or Contact Lenses						
Cataracts						
Glaucoma						
Diabetic Retinopathy						
Other (describe):						

**EARS**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Hearing Loss						
Balance Problems						
Other (describe):						

**NOSE / MOUTH / THROAT**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Sinus Congestion (frequent)						
Other (describe):						

**RESPIRATORY**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Asthma						
Bronchitis						
Emphysema						
Pneumonia						
Tuberculosis						
Other (describe):						

**DERMATOLOGICAL**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
ECZEMA (SEVERE DRY SKIN)						
LEG OR FOOT ULCERS						
OTHER (DESCRIBE)						

**PSYCHOSOCIAL (BEHAVIOR)**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
ALCOHOLISM						
RECREATIONAL DRUGS						
DEPRESSION						
ANXIETY OR PANIC DISORDERS						
INSOMNIA						
EATING DISORDERS						
OTHER (DESCRIBE)						

**CANCER**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
TYPE						
LOCATION						
TYPE						
LOCATION						

**RENAL (KIDNEYS & URINARY)**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
BLADDER PROBLEMS						
URINARY TRACT INFECTION (FREQUENT)						
KIDNEY INFECTION						
KIDNEY STONES						
KIDNEY DISEASE (DESCRIBE)						
OTHER (DESCRIBE)						

### HEPATIC (LIVER)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
ELEVATED LIVER ENZYMES						
HEPATITIS						
CIRRHOSIS						
OTHER (DESCRIBE)						

### ENDOCRINE (METABOLISM)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
DIABETES (INSULIN DEPENDENT)						
DIABETES (ORAL MEDICATION)						
DIABETES (DIET CONTROLLED ONLY)						
HYPERTHYROID (OVER ACTIVE)						
HYPOTHYROID (UNDER ACTIVE)						
GOITER						
GOUT						
OTHER (DESCRIBE)						

### NEUROLOGICAL (NERVES)

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUED?	REVIEWER'S COMMENTS
MIGRAINE HEADACHES						
PARKINSON'S DISEASE						
CVA (STROKE)						
DIABETIC NEUROPATHY						
ALZHEIMER'S DISEASE						
EPILEPSY						
TIA (TRANSIENT ISCHAMIC ATTACK)						
OTHER (DESCRIBE)						

# Volunteer Information & Medical History

Are you now or have you been on any Medications?

Yes  No If yes, please list below.

## MEDICATIONS

MEDICATION	START DATE	STOP DATE	DOSAGE (strength i.e. mg., units, etc.)	FREQUENCY (times per day, week etc.)	REASON (also see diagnosis and surgery sections that follow)	FORM OF MEDICATION (liquid, pill, injectable, topical inhaler, suppository)

Are you allergic to or intolerant of any Medication?

Yes  No If yes, please list below.

## ALLERGIES to MEDICATIONS

MEDICATION	REACTION	DATE FIRST IDENTIFIED	REVIEWER'S COMMENTS

### OTHER ALLERGIES

Do you have any "non-medicine" allergies?

YES  NO

TYPE	REACTION	DATE FIRST IDENTIFIED	REVIEWER'S COMMENTS
ENVIRONMENTAL / SEASONAL			
ANIMAL			
FOODS (LIST)			

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**FEMALE REPRODUCTIVE**

DIAGNOSIS	YES	NO	DATE BEGUN	DATE ENDED	CONDITION CONTINUES?	REVIEWER'S COMMENTS
Infertility						
Cysts or Lumps in Breasts						
Endometriosis						
Yeast Infections (Frequent)						
Sexually Transmitted Disease(s) (Specify): _____						
Other (describe): _____						

Are you currently pregnant?    Yes    No

Are you currently breast feeding?    Yes    No

**CURRENT MENSTRUAL STATUS**

- Post-Menopausal, \_\_\_\_/\_\_\_\_/\_\_\_\_       Regular periods  
 Hysterectomy, date: \_\_\_\_/\_\_\_\_/\_\_\_\_       Irregular periods      Date of Last Period: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Have not yet begun menstruation       Hormone Replacement \*

**BIRTH CONTROL METHODS (Please check all that apply)**

- Tubal Ligation                       I.U.D.                                       None  
 Birth Control Pill \*                   Condoms                                   Other  
 Barrier (diaphragm, sponge)       Rhythm Method                       Partner with Vasectomy  
 Spermicide                               Abstinence  
 Depo-Provera™                       Norplant™                               Does not apply (Post-Menopausal or previous Hysterectomy)

\* Please list the names of these medications/hormones under

**MEDICATION INFORMATION on page 2.**

In case of emergency, contact: \_\_\_\_\_ | \_\_\_\_\_ | ( ) \_\_\_\_\_  
Name Relationship Phone

I certify that the information stated within is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Volunteer

\_\_\_\_\_  
Date

REVIEWED BY:

\_\_\_\_\_  
Signature of Reviewer

\_\_\_\_\_  
Date



