Regional CLINICAL RESEARCH Inc.

PARTICIPANT INFORMATION SHEET

~ PLEASE PRINT ~

Date of Birth _____/_____/_____
Month Day Year

Full Name _____ Sex: ❑ Male ❑ Female

Mailing Address _____

Street Address _____

❑ Home Phone _____ ❑ Cell _____ ❑ Work _____

Please ☑ preferred phone Is it okay to leave message? ❑ Yes ❑ No

E-mail Address _____

Emergency Contact _____ Relationship _____

Phone _____

List any current prescriptions and over the counter medications.

Medication	Dosage	Date Started	Reason for Use

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MEDICAL CONDITIONS, PAST AND PRESENT

		DESCRIBE CONDITION	YEAR DIAGNOSED
Head, Ear, Eye, Nose, Throat Conditions	❑ Yes, describe →		
High Blood Pressure	❑ Yes, describe →		
Heart Conditions	❑ Yes, describe →		
Lung Conditions	❑ Yes, describe →		
Stomach, Bowel Conditions	❑ Yes, describe →		
Liver Conditions	❑ Yes, describe →		
Bladder/Kidney Conditions	❑ Yes, describe →		
Neurological Conditions (headaches, seizures)	❑ Yes, describe →		
Blood Disorders (anemia)	❑ Yes, describe →		
Elevated Cholesterol	❑ Yes, describe →		
Thyroid Conditions	❑ Yes, describe →		
Diabetes	❑ Yes, describe →		
Bone/Muscle Conditions	❑ Yes, describe →		
Skin Conditions	❑ Yes, describe →		
Female/Male Conditions	❑ Yes, describe →		
Allergies (medications and environmental)	❑ Yes, describe →		
Cancer	❑ Yes, describe →		
Psychological Conditions (depression, anxiety)	❑ Yes, describe →		
Surgeries	❑ Yes, describe →		
Other, specify:	❑ Yes, describe →		
Other, specify:	❑ Yes, describe →		

Participant Signature/Date _____

Information Reviewed by: Initials _____ Date _____