BEACON CLINICAL RESEARCH, LLC
45 Pearl Street, Suites B & C, Brockton, MA 02301
Phone: 508-584-2030 Fax: 508-584-2036
Email: al@beaconclinical.com Website: www.beaconclinical.com

PATIENT HISTORY

Patient Information: Today's Date: ___________
Name: _______________________________________ MI: ______ SSN: ____________________
Address: ____________________________ City: ________________ State: _____ ZIP: _______
Home Phone: ___________________Work Phone: _______________ Cell: _________________
Usual Work Hours: _____________ Email: ____
Closest contact in case of emergency: ____
Phone Number: _______________ Relationship to patient: _________________________
Current primary care physician: _________________________ Phone: ____________________
Physician's office address: _________________________________ Fax number: _____________

May we contact your physician for medical records, if needed? Y or N (please circle one)

Demographic Information:
Date of birth: _____ /______ /______ Age: ______
Month Day Year

Race: □ White □ Black □ Hispanic
□ Asian or Pacific Islander
□ American Indian or Alaskan Native
□ Other (specify): _______________

Gender: □ Male □ Female
Height: ____ ft ____ inches Weight: _______ lbs
Occupation _____________________________

Current Medications:
Please list all current medications, including prescription and over-the-counter medication, as well as herbal or vitamin supplements. Please continue on back if more space is needed.

Name of Drug	Reason	Daily Dose	Start Date

Please check here if list is continued on back □

Previous Medications
Please list any previous medications taken for high blood pressure, diabetes, cholesterol, osteoporosis, arthritis, hormones for menopause, or weight loss.

Name of Drug	Reason	Daily Dose	Start Date	Stop Date

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Allergy History:
List any medication allergies that you have: ____
List any other allergies you have (food, animals, seasonal, etc): ___________________________
____

Alcohol History:
Do you drink alcoholic beverages on a regular basis?

□ Yes If yes, please estimate the amount of alcohol Consumed per week:
_____ units wine (I unit equals 4oz)
_____ units beer (1 unit equals 12oz)
_____ units liquor (1 unit equals 2 oz)

□ No If no, did you previously use alcohol on a regular basis?
□ Yes
□ No

Smoking History:
Describe your current level of tobacco use:
□Never smoked cigarettes
□Smoke _____ cigarettes per day (1 pack equals 20 cigarettes)
□Past smoker (Year stopped: ________)
□ Smoke pipes
□Smoke cigars
□ Use Chewing tobacco

Family History:
Has your mother, father, sister, brother, children or grandparents had any of the following?

	Yes	**No**	**Don't know**	**Who and what age?**
Heart Disease (see below for examples)	□	□	□	____________________
Kidney Disease	□	□	□	____________________
Diabetes	□	□	□	____________________
High Blood Pressure	□	□	□	____________________
Stroke	□	□	□	____________________
High Cholesterol	□	□	□	____________________
Cancer	□	□	□	____________________

Heart Disease History:
Please complete the following indicating if **you** have had any of the following conditions.

	Y or N	**Year**	**Details**
Heart Attack	_____	______	____________________

Angina (chest pain)	______	_______	___________________________
Heart bypass surgery	______	_______	___________________________
Angioplasty	______	_______	___________________________
Stroke	______	_______	___________________________
Congestive Heart Failure	______	_______	___________________________
Blood clots in leg or lung	______	_______	___________________________
Arrhythmia (irregular heart beat)	______	_______	___________________________
Transient Ischemic Attack (mini-stroke)	______	_______	___________________________
Other artery bypass	______	_______	___________________________
Edema (swelling in lower legs)	______	_______	___________________________
Other (specify)	______	_______	___________________________

Risk factors for coronary heart disease:
Please indicate Yes or No to the following statements:

You are a male 45 years of age or older _______
You are a female 55 years of age or older ______
You are a post-menopausal woman NOT on estrogen replacement therapy _______
Father and/or brother had a heart attack before age 55 ______
Mother and/or sister had a heart attack before age 65 ______
You currently smoke cigarettes ______
You have high blood pressure ______
You have diabetes ________

General Medical History
Please indicate Yes or No if you currently have, or have a history of, any of the following conditions. Please include the year of diagnosis or onset and any details pertaining to the condition.

Cardiovascular

	Y or N	**Year**	**Details**
High Cholesterol	______	_______	___________________________
High Blood Pressure	______	_______	___________________________
Other (specify):	______	_______	___________________________

Gastrointestinal

	Y or N	**Year**	**Details**
Indigestion / Dyspepsia	______	_______	___________________________
GERD / Acid Reflux	______	_______	___________________________
Frequent Constipation	______	_______	___________________________

Frequent Diarrhea	______	_______	___________________________
Irritable Bowel	______	_______	___________________________
Inflammatory Bowel	______	_______	___________________________
Hemorrhoids	______	_______	___________________________
Hiatal Hernia	______	_______	___________________________
Gallstones	______	_______	___________________________
Pancreatitis	______	_______	___________________________
Hepatitis	______	_______	___________________________
Lactose Intolerance	______	_______	___________________________
Other (specify):	______	_______	___________________________

Musculoskeletal

	Y or N	Year	Details
Frequent Lower Back Pain	______	_______	___________________________
Fibromyalgia	______	_______	___________________________
Degenerative Joint Disease	______	_______	___________________________
Osteoarthritis	______	_______	___________________________
Rheumatoid Arthritis	______	_______	___________________________
Frequent Muscle Aches	______	_______	___________________________
Osteoporosis	______	_______	___________________________
Other (specify):	______	_______	___________________________

Respiratory

	Y or N	Year	Details
Asthma	______	_______	___________________________
COPD	______	_______	___________________________
Hay fever / sinusitis	______	_______	___________________________
Bronchitis	______	_______	___________________________
Other (specify):	______	_______	________________________

Neurological

	Y or N	Year	Details
Migraine Headaches	______	_______	___________________________
Frequent Tension Headaches	______	_______	___________________________
Frequent sinus headaches	______	_______	___________________________
Seizure disorder	______	_______	___________________________
Dementia / Alzheimer's Disease	______	_______	___________________________
Parkinson's disease	______	_______	___________________________
Peripheral neuropathy	______	_______	___________________________
Bell's palsy	______	_______	___________________________

Vertigo (dizzy spells)	______	_______	____________________________
Neuropathic pain condition	______	_______	____________________________
Other (specify)	______	_______	____________________________

Eye

	Y or N	Year	Details
Cataracts	______	_______	____________________________
Glaucoma	______	_______	____________________________
Retinopathy	______	_______	____________________________
Vision Correction	______	_______	____________________________
Other (specify)	______	_______	____________________________

Ear

	Y or N	Year	Details
Tinnitis (Ringing in ears)	______	_______	____________________________
Hearing Loss	______	_______	____________________________
Other (specify)	______	_______	____________________________

Endocrine

	Y or N	Year	Details
Obesity	______	_______	____________________________
Thyroid Disease	______	_______	____________________________
Diabetes: □ Type I or □ Type II	______	_______	____________________________
Other (specify)	______	_______	____________________________

Dermatological

	Y or N	Year	Details
Dermatitis / Eczema	______	_______	____________________________
Psoriasis	______	_______	____________________________
Uticaria / Hives	______	_______	____________________________
Other (specify)	______	_______	____________________________

Psychological

	Y or N	Year	Details
Sleep Disorder	______	_______	____________________________
Depression	______	_______	____________________________
Anxiety/Panic Disorder	______	_______	____________________________
ADHD	______	_______	____________________________
OCD	______	_______	____________________________
Eating disorder (anorexia/bulimia)	______	_______	____________________________

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Other (specify):	______	_______	___________________________

Renal / Urinary

	Y or N	Year	Details
Enlarged Prostate	______	_______	___________________________
Erectile Dysfunction/Impotence	______	_______	___________________________
Urinary Incontinence	______	_______	___________________________
Frequent urinary tract infections	______	_______	___________________________
Kidney Stones	______	_______	___________________________
Renal Insufficiency	______	_______	___________________________
Other (specify):	______	_______	___________________________

Immunological / Other

	Y or N	Year	Details
HIV/AIDS	______	_______	___________________________
Lupus	______	_______	___________________________
Anemia	______	_______	___________________________
Genetic Disease	______	_______	___________________________
Herpes Zoster / Shingles	______	_______	___________________________
Other (specify)	______	_______	___________________________

Cancer:
Have you had any type of cancer? **Y or N** Year Diagnosed: _________ Type: _________________

Other Health History
Please provide the dates and details of any surgeries or hospitalizations. Also, list and give details pertaining to any other health conditions not already listed.
____
____
____

May we contact you for future studies for which you may be eligible to participate?
□ **Yes** □ **No** if yes, please circle the types of studies that interest you:

Cholesterol	Weight Loss	Depression
Osteoporosis	Diabetes	Allergies
Urinary Incontinence	Irritable Bowel Syndrome	Other: _________________________________
Headache	Arthritis	
High Blood Pressure	Asthma	
Gastric Reflux Syndrome	Bronchitis/ Pulmonary Disease	

Signature: ____ **Date:** _________________________

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Patient History Reviewed By: _______________________________ Date: __________________________

FEMALES ONLY, PLEASE COMPLETE BELOW

Are you able to have children?

□ **Yes**
Please circle the method (s) of birth control you Use:
Oral contraceptives
Barrier method (diaphragm, condom, IUD)
Male partner had vasectomy
Abstinence
Other: ____________________
When was your last menstrual period? ___________

□**No**
If no, have you……
Had your tubes tied? Y or N Year: ____
Had a hysterectomy? Y or N Year: ____
Had your ovaries removed? Y or N Year:____
If yes, please circle: One Both Don't Know
Gone through Menopause? Y or N
If yes, when was your last menstrual period: ____________

Please indicate whether you currently experience or have a history of the following:

Chronic back pain: __________
Curvature of spine: _________
Prior non-traumatic fractures during your adult life (list sites and dates on back of page): ____________
Pre-menstrual syndrome or painful menstrual cycle: ____________
Endometriosis: _________
Genital Herpes / Venereal disease: ___________
Fibroid Tumors: ____________
Ovarian cysts:________
Infertility: ___________

Please complete the following sections if you are post-menopausal and over the age of 50.

Do you currently take hormones, such as estrogen or Premarin? Y or N
If no, have you ever taken hormones in the past, including birth control pills? Y or N

Do you take a daily calcium supplement? Y or N How much calcium does it provide? _______ mg/day

Risk Factors for Osteoporosis
Please indication Yes or No to the following:

Caucasian or Asian: ____
Onset of menstrual periods after age 16: ____
Menopause before age 45: _____
Consume less than 3 servings of dairy products a day? _____ (serving=8oz milk, 1.5oz cheese, 1 cup yogurt)
Do you drink 2 or more alcoholic beverages per day?: _____

Do you drink 3 or more caffeinated beverages a day?: _____
Do you currently smoke more than a half pack of cigarettes a day? _____
Do you exercise less than 3 times a week?:_____
Do you have a family history of osteoporosis or hip fracture?: ____
Do you take medications that contain steroids, such as prednisone or cortisone?_____
Have you experienced a loss of height greater than 2 inches?:_____