NOVAK CLINICAL RESEARCH
DEMOGRAPHIC FORM

(Any mistakes should be fixed by a single line through and initial and date by it as the next example: ~~NOVAK~~ IN 01/01/2021)

Patient Name:			Gender:
Date of Birth:		Last 4 digits of SSN:	
Marital Status:	Language:		
Race: (e.g., African American, Latino, Asian, etc.):			
Ethnicity (e.g., Mexican, Hawaiian, Irish, etc.):			
Address:			
City:	State:	Zip:	
Phone:	Cell Phone	Work:	
Email:			
What is the preferred method that we should use to contact you? ☐ Home # ☐ Mobile # ☐ Email ☐ Text Message			
Best Time? ☐ AM ☐ PM	Is it ok to leave a message? ☐ Yes ☐ No		
Primary Care Doctor:	Doctor's Number:	Fax:	
Specialist (if applicable):	Doctor's Number:	Fax:	
Specialist (if applicable):	Doctor's Number:	Fax:	

Does someone have power of attorney or healthcare proxy giving them the power to make decisions about your care in life-threatening situations? ☐ Yes ☐ No
(Name of person and their relationship to you) _____

Emergency Contact Information
Emergency Contact #: _____ Relation: _____

Phone Number: _____ Email: _____

Would you be interested in being contacted from us to participate in future studies? ☐ Yes ☐ No

I have completed all questions and certify that this information is true and correct to the best of my knowledge.
Patient Signature: _____ Reviewer signature: _____
Date:_____ Date:_____

Please indicate whether you have experienced any of the following medical problems? Please Circle Yes or No for all questions.

Do you currently have, or have you ever had any of the following diagnosed by a healthcare provider?			**Staff use only**			
Respiratory	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
URI (cold) now	Y	N			☐	
Chronic Cough	Y	N			☐	
COPD / Emphysema / Chronic Bronchitis	Y	N			☐	
Asthma	Y	N			☐	
Other:	Y	N			☐	
Cardiovascular	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
High Blood Pressure	Y	N			☐	
High Cholesterol	Y	N			☐	
Edema	Y	N			☐	
Arrhythmia	Y	N			☐	
Blood Clots	Y	N			☐	
Heart Attack	Y	N			☐	
Chest Pain/Angina	Y	N			☐	
Stroke	Y	N			☐	
Other:	Y	N			☐	
Endocrine	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
Hypothyroidism	Y	N			☐	
Hyperthyroidism	Y	N			☐	
Diabetes (Type I or II)	Y	N			☐	
Change in Hair Growth	Y	N			☐	
Other:	Y	N			☐	

Do you currently have, or have you ever had any of the following diagnosed by a healthcare provider?			**Staff use only**			
Locomotor - Musculoskeletal	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
Varicose Veins	Y	N			☐	
Osteoarthritis	Y	N			☐	
Rheumatoid Arthritis	Y	N			☐	
Gout	Y	N			☐	
Low Back Pain	Y	N			☐	
Fibromyalgia	Y	N			☐	
Carpal Tunnel Syndrome	Y	N			☐	
Claudication (Calf Pain)	Y	N			☐	
Others:	Y	N			☐	
Gastrointestinal	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
Heartburn	Y	N			☐	
Gastric/Duodenal Ulcer	Y	N			☐	
Gallbladder Disease	Y	N			☐	
Hepatitis A, B, or C	Y	N			☐	
Constipation	Y	N			☐	
Black Stool/ Bleeding	Y	N			☐	
Hemorrhoids or Piles	Y	N			☐	
Frequent Diarrhea)	Y	N			☐	
Irritable Bowel Syndrome	Y	N			☐	
Difficult Swallowing	Y	N			☐	
Others:	Y	N			☐	

Do you currently have, or have you ever had any of the following diagnosed by a healthcare provider?			**Staff use only**			
Neuro-Psychiatric	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
Epilepsy	Y	N			☐	
Convulsions/Seizures	Y	N			☐	
Episodes of Unconsciousness	Y	N			☐	
Paralysis	Y	N			☐	
Depression	Y	N			☐	
Insomnia	Y	N			☐	
Migraines	Y	N			☐	
Anxiety	Y	N			☐	
Others:	Y	N			☐	
Hematology	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
HIIV / Aids	Y	N			☐	
Cancer, specify:	Y	N			☐	
Blood Disease	Y	N			☐	
Anemia	Y	N			☐	
Abnormal Bruising or bleeding	Y	N			☐	
Other:	Y	N			☐	

Do you currently have, or have you ever had any of the following diagnosed by a healthcare provider?			**Staff use only**			
Allergies	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
Drug Allergies (e.g., penicillin-hives) specify: _____	Y	N			☐	
Environmental Allergies (e.g., Dust, Mold, Pollen, Grass) specify: _____	Y	N			☐	
Food Allergies (e.g., Nuts-hives) specify: _____	Y	N			☐	
Animal Allergies (e.g., Cat-hives) specify: _____	Y	N			☐	
Other Allergies: _____	Y	N			☐	
Men Only	**Circle Yes(Y)or No(N)**		**Start Date**	**Stop Date**	**Check if Ongoing**	**Notes during review, clarify all "yes" answers & other relevant information:**
Prostate problems	Y	N			☐	
Vasectomy	Y	N	Date when vasectomy was done: _____			
Other problems:	Y	N				
Women Only	**Circle Yes(Y)or No(N)**					
Are you of child bearing potential?	Y	N	If yes, when was the first day of your last period? _____			
Birth Control?	Y	N	☐ None ☐ NA-Menopause ☐ Tubal Ligation ☐ Hysterectomy ☐ Birth-control pill/Vaginal Ring/Depo injection ☐ Other, specify:_____			

Surgical procedure/Hospitalization History: ☐None

Please list your surgical procedures or reasons for hospitalizations below with their approximate date:

Surgical procedure		Reason	Date
1			
2			
3			
4			
Hospitalization		**Reason**	**Date**
1			
2			
3			
4			

Family History					
Mother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Father:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Brother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Sister	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Grandmother:	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Grandfather	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Aunt	☐ Hypertension	☐ Diabetes	☐ Cancer	☐ Other (please specify):	☐ N/A
Uncle	☐ Hypertension	☐ Diabetes	☐Cancer	☐ Other (please specify):	☐ N/A

Tobacco Use		
Cigarettes ☐Yes ☐ No	☐ Current: Smoker: packs/day____. # of years _____. Start date: _____	☐ Former Quit: Stop Date_____ years _____
☐ Other Tobacco: ☐Pipe ☐Cigar ☐Snuff ☐Chew	☐ Current: Start date: _____	☐ Former Quit: Stop Date_____ years _____

Alcohol

Do you drink alcohol? ☐No ☐Yes

If yes, # drinks/day____ week_____

☐ Former Quit: Stop Date_____ # of years that you drink _____

Drug Use

Do you use cannabis? ☐No ☐Yes

If yes, # of times/day_____ week _____

Do you use any other recreational drugs? ☐ No ☐ Yes Specify: _____	Have you ever used needles? ☐ No ☐ Yes

Medications: ☐ None

Do you take any medications, vitamins, birth control, homeopathic remedies? Complete below:

	Medication Name	Dose	Frequency	Reason	Start Date	Stop Date
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
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21						
22						
23						
24						
25						
26						
27						
28						
29						

Dated Statement:

I certify that "I have not taken any investigational medication within the past (please encircle one):
" Never / 30 / 60 / 90/ 120 days or more. Patient's Initials: _____