Santé Clinical Research
1230 Bandera Hwy
Kerrville, Texas 78028

First & Last Name: _____

Today's date: _____

Mailing Address: _____

City: _____ State_____ Zip Code:_____

Date of birth

Circle One Month: Jan/ Feb/ Mar/ Apr/May/Jun/Jul/Aug/Sep/Oct/Nov/Dec

Day _____Year_____ DOB: _____

Age: _____ Sex at Birth: □ Male □ Female □Unknown

Self-Reported Ethnicity & Race: □Asian □Native American □White (Caucasian) □Black

Select ONE: □Hispanic □ Not Hispanic

Phone Number#: _____-_____-_____ Second#: _____-_____-_____

(Indicate who's phone number the second # belongs to: _____)

E- mail Address:_____

□YES □ NO Can we send you visit reminders, trial info and information on upcoming study opportunities?

Preferred Methods of Contact: **Call me** **Text me** **Email me**

Where did you hear about us from?

☐ Flyer/ Poster/ Brochure ☐ Facebook ☐ Website ☐ Radio/ Television Ad
☐ Word of mouth _____ ☐ Other (Specify) _____

EMERGENCY Contact Name: _____Ph#_____

Relation:_____

Smoking History

□**Never Smoked**

□**Previous Smoker, Start** _____ Stopped _____

Number of packs per day _____ # of years smoked _____

□**Current Smoker: Start** _____

Number of packs per day _____ # of years smoked _____

E-Cig Use? □**Never Used** □ **Ex-user** □**Current User**

If Current user: What is your nicotine percentage?

Start date:_____ **Stop date:**_____

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Alcohol History

□**Never Used** □ **Ex-user** Start date _____ □ Stop date_____

□**Currently User** □Occasional □Social □ Daily #/day_____

Primary Consumption: □Wine □Beer □ Liquor

Medication Allergies? 1. _____ 2. _____ 3. _____	**YES**	**NO**	
Latex Allergy?	**Yes**	**No**	
Eyes, Ears Nose, Throat & Respiratory	**Yes**	**NO**	**Year Diagnosed** / Extra Info
Seasonal Allergies- ex: Cedar, Oak, Pollens			
Perennial Allergies- Cat/Dog/Mold/Dust			
Asthma			
COPD- Chronic Obstructive Pulmonary			
Chronic Bronchitis			
Emphysema			
Cataract Removal			□Left □Right □ Both Eyes
Tonsil Removal			
Psoriasis			
Eczema			
Circulatory & Nervous System	**Yes**	**NO**	**Year Diagnosed** / Extra Info
Hypertension- High Blood Pressure			
Hypotension- Low Blood Pressure			
Hyperlipidemia- High Cholesterol			
Coronary Artery Disease			
Stroke (mark if more than one)			
Transient Ischemic Attack- TIA			
Frequent Chest Pain			
Congestive Heart Failure			
Heart Attack- if yes list year occurred			
Heart Surgery- be specific if possible			
Seizures			
Migraines			
Endocrinology	**Yes**	**NO**	**Year Diagnosed** / Extra Info

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Type II Diabetes			
Type I Diabetes (from birth or childhood)			
Diabetic Neuropathy—Toe/Foot numbness			
Diabetic Retinopathy- Eye problems from Diabetes			
Diabetic Nephropathy- Kidney problems from Diabetes			
Hyperthyroidism (Over active thyroid)			
Hypothyroidism (Under active thyroid)			
Obesity or Overweight			
Gastrointestinal	**Yes**	**NO**	**Year Diagnosed** / Extra Info
Hepatitis □A □B			
Hepatitis C – Active or Dormant?			
GERD (Reflux or Heartburn)			
Irritable Bowel Syndrome			
Diverticulitis			
Gastric Bypass Surgery- list year			List year-
Lap Band Surgery- list year			List year-
Pancreatitis in the past			List year-
Frequent Constipation			
Frequent Diarrhea			
Frequent Vomiting			
Gastroparesis			
Genitourinary	**Yes**	**NO**	**Year Diagnosed** / Extra Info
Bladder Incontinence			
Frequent Kidney Stones			
Any Diagnosed Kidney Problems?			
Benign Prostatic Hyperplasia- BPH or Enlarged Prostate			
Erectile Dysfunction			
Breast Nodules			Biopsy: Yes or No?
Hysterectomy			Full or Partial
Tubal Ligation			
C-Section – list year(s) if more than one			
Psychological	Yes	NO	**Year Diagnosed** / Extra Info
Anxiety			
Depression			
Schizophrenia			
Bipolar Disorder			
ADD or ADHD			

Alcohol or Substance Abuse?			
Drug or alcohol abuse that required inpatient therapy?			
OTHER	**Yes**	**NO**	**Year Diagnosed** / Extra Info
Cancer in the Last 5 years			
Treatment with Steroids			
Organ Transplant			
Blood Transfusion			
Any Amputations?			
TATTOOS/ Body Piercings			
HIV/AIDS			
Anything additional Medically Important?			

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Contraception Form

***IF YOU PLAN TO GET PREGNANT OR HAVE YOUR PARTNER BECOME PREGNANT NOTIFY OUR STAFF IMMEDIATELY!**

It is important that we try and obtain as much Contraception information so that we do not perform urine or serum pregnancy tests on women that it is not applicable for. In addition, per protocol we MUST test all women of child bearing potential for pregnancy.

Contraception for Men

Please indicate which way you plan on protecting your sexual partner from getting pregnant while in a trial. Please indicate below your method of contraception.

Options include:

1. Vasectomy
2. Abstinence (not having sex with a partner)
3. Condoms & Spermicide

Male Only:

□ Vasectomy Date: _____/____/_____ □True Abstinence □Condoms& Spermicides

Patient Initials_____

Contraception for Women

IF YOU STILL HAVE A UTERUS and are not in Menopause- you MUST use an acceptable form of birth control. Check form below for acceptable form of birth control.

Date of last Menstrual Cycle_____/_____/_____ □ Unknown

Methods of acceptable birth control:

□ Oral Contraceptive (Pill) □IUD (Ex: Mirena) □Patch □Injectable (Ex: Depo-Provera)

□IF YOU STILL HAVE A UTERUS YOU MUST USE ONE OF THE ABOVE FORMS OF BIRTH CONTROL OR USE THE DOUBLE BARRIER METHOD- This is Condoms and a Spermicide. Check this box that you agree to use this form of birth control you agree to use throughout study participation.

□ Hysterectomy Date: _____/_____/_____ □ Full or □Partial Hysterectomy

□ Bilateral tubal ligation date: _____/_____/_____

□ Menopause Start Date: _____/_____/_____

** IT IS VITAL THAT IF YOU ARE ENROLLED INTO A TRIAL THAT YOU CONTACT STUDY STAFF IF YOU BECOMEPREGNANT OR ARE TRYING TO GET PREGNANT! **

Patient Initials_____