

Welcome to New Horizons Clinical Research

Thank you for your interest in our research study. We, the staff of New Horizons Clinical Research Center, are committed to providing excellence in clinical research and customer service. If at any time you feel we can improve in any area, please don't hesitate to inform us.

Please complete the following forms as accurately as possible so that we may be aware of your health history.

Should you qualify for this clinical study, you will receive your compensation 2-3 weeks after the last visit is completed (unless otherwise specified in the consent form) and all study medication and diaries have been returned.

Thank you for your time and participation. We are delighted to have the opportunity to evaluate you for our study.

Sincerely,

Gregory M. Gottschlich, M.D.
Principal Investigator

NEW HORIZONS CLINICAL RESEARCH
PERSONAL HEALTH HISTORY

Subject Name _____

Date ____/____/____

Have you ever had, or do you now have, any of the following: (Please check the appropriate answer)

CONDITION Circle one option if applicable	Y	N	COMMENTS	CONDITION	Y	N	COMMENTS
1. Allergy to Medicines				30. Kidney Disease			
2. Allergies: Seasonal – Fall/Spring				31. Liver Disease/Hepatitis			
3. Allergies: Perennial/Food				32. Gall bladder Disease			
4. Asthma				33. Chronic Heartburn/Acid Reflux			
5. Chronic Cough/Bronchitis				34. GI Ulcer			
6. Emphysema/COPD				35. Chronic Constipation			
7. Tuberculosis				36. Chronic Diarrhea			
8. Sleep Apnea				37. Chronic Back Pain			
9. Trouble Hearing				38. Sciatica			
10. Headaches				39. Arthritis – Osteo/Rheumatoid			
11. Eye Problems/Disease				40. Chronic swelling in legs or feet			
12. Depression				41. Osteoporosis			
13. Anxiety				42. Osteopenia			
14. Insomnia				43. Prostate Problems/Disease			
15. Immune System Disorder				44. Psychiatric Disorder			
16. Menopause				45. Fibromyalgia			
17. Thyroid Disease				46. Skin Disease			
18. Shortness of Breath with exertion				47. Epilepsy/Seizure Disorder			
19. Heart Murmur				48. Anemia			
20. Arrhythmia/Palpitations				49. Alcohol or Drug Abuse			
21. Angina/Chest Pain				50. Skin Cancer - Type			
22. History of Heart Attack/MI				51. Cancer - Type			
23. History of Angioplasty/By-pass				52.			
24. Heart Disease - Other				53.			
25. High Blood Pressure				54.			
26. High Cholesterol				55.			
27. Diabetes – Diet only Insulin or Oral				56.			

Staff Initials _____ / Date _____

Patient Initials _____ / Date _____

**NEW HORIZONS CLINICAL RESEARCH .
PERSONAL HEALTH HISTORY**

Subject Name _____

Subject Initials _____

Date ___/___/___

MEDICATION HISTORY: List all medications, including prescription, over the counter, vitamins, etc., which you are currently taking or have taken in the past 3 months. (If NONE, indicate)

MEDICATION	DOSE	START DATE	STOP DATE	IF CONTINUING MEDICATION CIRCLE:	REASON FOR TAKING
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	
		___/___/___	___/___/___	CONT.	

LIST ALL SURGERIES	DATE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

<p>FAMILY HISTORY: List all diseases within your immediate family.(e.g., cancer, diabetes, etc.)</p> <table border="0"> <tr> <td style="width: 50%;">RELATIVE</td> <td style="width: 50%;">DISEASE</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> </table>	RELATIVE	DISEASE	_____	_____	_____	_____	_____	_____	<p>SOCIAL HISTORY:</p> <p>DO YOU SMOKE OR HAVE YOU EVER SMOKED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DATE STARTED: ___/___/___ DATE STOPPED: ___/___/___</p> <p>TYPE: _____ AMOUNT: _____ packs per day</p> <p>ALCOHOL USE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>TYPE: _____ AMOUNT: _____/wk</p>
RELATIVE	DISEASE								
_____	_____								
_____	_____								
_____	_____								

FEMALE PATIENTS ONLY:

DATE OF LAST MENSTRUAL PERIOD? ___/___/___ (If exact date is not known, put approximate date)

Method of Birth Control? Surgically Sterile (Tubal Ligation, Hysterectomy) Date of procedure _____
 Naturally Post Menopausal Depo Provera Injection Implant Patch
 Oral contraceptives Diaphragm Condoms Foam/Gel Abstinence

Staff Initials _____ / Date _____	Patient Initials _____ / Date _____
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New Horizons Clinical Research
4260 Glendale Milford Rd. Suite 201
Cincinnati, Ohio 45242

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(513) 769-2767 Fax (513) 733-8677

Regarding:

I, the undersigned hereby grant my permission for release/exchange of information relating to the care of the above captioned person, between New Horizons Clinical Research and:

The permission includes a release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, drug or related conditions, and/or psychiatric/psychological conditions. The purpose of this release of information is to provide continuity of care, to assist in assessment and/or treatment planning, for inclusion for participation in a clinical research study, or to meet another specific request desire of mine. I specify that this release is to include:

The following information may be released or reviewed:

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Mental Health/Substance Abuse
<input type="checkbox"/> Entire Medical Record	<input type="checkbox"/> X-Ray Films	<input type="checkbox"/> Psychological Reports
<input type="checkbox"/> History/Physical Examination	<input type="checkbox"/> Court Records	<input type="checkbox"/> Social History
<input type="checkbox"/> Immunizations (Shot) Records	<input type="checkbox"/> Educational Records	<input type="checkbox"/> Social History
<input type="checkbox"/> Lab	<input type="checkbox"/> Medications Prescribed	<input type="checkbox"/> Social History
<input type="checkbox"/> Operative Report		

Other (Specify) _____

Dates of Treatment: _____

The above information is to be released/exchanged to:

Name: _____

Street Address: _____

City, State, and Zip Code: _____

This statement must be signed and dated, and may be revoked at any time except to the extent action has been taken prior to revocation. This consent will expire (60) days after the date below, or sooner by my choice, in which case this consent will expire on _____.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records for purpose and extent stated above and release the above named institute of any claim pertaining to the release and use of medical data or the contents thereof.

Patient's Name: _____ Signature: _____

Street Address: _____ Legal Guardian: _____

City, State, Zip Code: _____

Birth date: _____ Today's Date: _____

Witness: _____ Telephone: _____

If there is a charge for medical records, please contact New Horizons prior to sending records.

ANY REDISCLOSURE OF MEDICAL INFORMATION BY THE RECIPIENT IS PROHIBITED

New Horizons Clinical Research

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Jeanette Wiesner**

Telephone: **(513) 769-2767**

e-mail: **newhorizons1@fuse.net**

Address: **4260 Glendale-Milford Road Cincinnati, OH 45242**

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.