Without participants like you, there would be no advancement in medicine!

.
The satisfaction of our participants is one of our highest priorities. That's why we have a staff of highly experienced medical professionals that provide exceptional care in a comfortable environment.

You will work with a clinical research team who will provide specific information about the trial in which you are participating. The clinical trial team consists of doctors, nurses and other health care professionals. They will check your health at the beginning of the trial, give you instructions for your participation in the trial, monitor your condition throughout the trial and will instruct you on how to keep in touch after the trial is finished.

As a first step, please complete the following forms as accurately as possible, so that we may be aware of your health history

Should you qualify to participate, you will receive compensation for your time and travel within 1 week after each completed visit.

A sincere thank you to all of the men and women who take part in our clinical research studies each year.

By choosing to participate you become a true hero!

New Horizons
CLINICAL RESEARCH

PATIENT REGISTRATION FORM

NAME: Nickname: Date:

(first) (middle) (last)

ADDRESS:

(city) (state) (zip code)

HOME PHONE: **WORK PHONE:**

CELL PHONE: **OTHER PHONE:**

EMAIL ADDRESS:

DATE OF BIRTH: **Age:** **Gender:** **Male**☐ **Female**☐

RACE: Black or African American ☐ White or Caucasian☐ Native American☐ Asian☐ Other☐_____

Ethnicity: Hispanic ☐ Not Hispanic ☐

EMPLOYER: **OCCUPATION:**

EMERGENCY INFORMATION

EMERGENCY CONTACT: **Phone:**

RELATIONSHIP TO PATIENT:

SECONDARY EMERGENCY CONTACT: **Phone:**

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN:

COMPANY/FACILITY NAME:

PHYSICIAN'S ADDRESS:

PHYSICIAN'S PHONE: **FAX:**

May we contact your physician(s) to obtain medical records? **Yes** ☐ **No** ☐

SPECIALIST PHYSICIAN:

For Staff Only:

PCP Notification Sent? ☐ **Y** ☐ **N**

Date Sent: / / **Staff Initials:**

SPECIALIST'S ADDRESS:

SPECIALIST'S PHONE: **FAX:**

TYPES OF STUDIES YOU ARE INTERESTED IN:

Allergy ☐ Asthma ☐ Pediatric Asthma ☐ Sinusitis ☐ Arthritis ☐ Diabetes ☐ Overnight studies☐

Pain ☐ Cholesterol☐ Gout ☐ Hypertension ☐ Irritable Bowel ☐ Other☐_____

Have you participated in another research study in the last 30 days? Yes _____ No_____

HOW DID YOU HEAR ABOUT OUR RESEARCH CENTER? PLEASE SPECIFY

Patient of Allergy & Asthma Affiliates☐ Friend/Family☐ Radio (station)_____ Magazine/Newspaper (specify)☐ _____

TV (channel)☐_____ Mail☐ Website☐ _____ Facebook/Twitter☐ Referred by physician☐

Physician's name:_____

PERSONAL HEALTH HISTORY

New Horizons CLINICAL RESEARCH

ject 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. Eye Problems/Disease			
2. Allergies: Seasonal – Fall/Spring				31. Kidney Disease			
3. Allergies: Perennial/Food				32. Liver Disease/Hepatitis			
4. Latex Allergy				33. Gall bladder Disease			
5. Asthma				34. Chronic Heartburn/Acid Reflux			
6. Chronic Cough/Bronchitis				35. Irritable Bowel Syndrome			
7. Emphysema/COPD				36. Chronic Constipation			
8. Tuberculosis				37. Chronic Diarrhea			
9. Sleep Apnea				38. Chronic Back Pain			
10. Migraine				39. Sciatica			
11. BiPolar Disorder				40. Arthritis – Osteo/Rheumatoid			
12. Depression				41. Chronic swelling in legs or feet			
13. Anxiety				42. Osteoporosis			
14. Insomnia				43. Fibromyalgia			
15. Immune System Disorder				44. Prostate Problems/Disease			
16. Menopause				45. Low Testosterone			
17. Thyroid Disease				46. Anemia			

18. Skin Disease				47. Diabetes Type I – insulin dependent			
19. Gout				48. Epilepsy/Seizure Disorder			
20. Arrhythmia /Palpitations				49. Alcohol or Drug Abuse			
21. Angina/Chest Pain				50. Cancer - Type			
22. History of Heart Attack /MI				51. Skin Cancer - Type			
23. History of Angioplasty/By-pass				**Procedures**			
24. Heart Disease - Other				1. Bowel Resection			
25. High Blood Pressure				2. Gastric Bypass			
26. High Cholesterol				3. Joint Replacement			
27. Diabetes – Type II diet or med controlled				4			

_____/_____ _____/_____

Staff Initials Date **Patient Initials Date**

PERSONAL HEALTH HISTORY

New Horizons CLINICAL RESEARCH

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY: List all diseases within your immediate family. (e.g., cancer, diabetes, etc.)

RELATIVE **DISEASE**

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY:

DO YOU SMOKE OR HAVE YOU EVER SMOKED?

__YES ___NO

DATE STARTED: ___/___/___ DATE STOPPED:___/___/___

TYPE:_____ AMOUNT: ____packs per day

ALCOHOL USE? __YES __NO

TYPE:_____ AMOUNT:____/wk.

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

Are you currently pregnant or nursing? __YES __NO

_____/_____ _____/_____

Staff Initials Date **Patient Initials Date**

New Horizons Clinical Research
4260 Glendale Milford Road Suite 201
Cincinnati, Ohio 45242
(513) 769-2767 Fax (513) 733-8677

New Horizons Clinical Research
9395 Kenwood Road Suite 101
Cincinnati, Ohio 45242
(513) 769-2770 Fax (513) 745-9043

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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:

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

Other (Specify) _____

Dates of Treatment: _____

The above information is to be released/exchanged to:

☐ New Horizons Clinical Research
4260 Glendale Milford Road, Suite 201
Cincinnati, Ohio 45242

or

☐ New Horizons Clinical Research
9395 Kenwood Road, Suite 101
Cincinnati, Ohio 45242

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