Austin Institute for Clinical Research
Patient Demographics

First Name: _____ **Last name:** _____ **Middle Initial:** ____

Date of Birth: _____ **Gender (at Birth):** _____ **Social Security**: _____-_____-_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **OK to use for correspondence? Y or N*

*Referred by*_____

Ethnicity: ☐ Hispanic or Latin ☐ Not Hispanic or Latin ☐ Refuse to report

Language: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ Asian ☐ African American ☐ Caucasian ☐ American Indian ☐ Other race _____

Emergency Contact:

Name_____Phone_____ Relationship_____

Primary Care Physician: _____Phone:_____

Allergies: NONE ☐

Please list all medications, foods, and herbals that you have allergies or adverse reactions to; and the type of reaction:

Medication or Food:	Reaction:
_____	_____
_____	_____

Current Medications:

Please list all medications, vitamins, and herbals you are currently taking; prescribed or over-the-counter: NONE ☐

Name of Medication:	Reason for taking: (ie diabetes)	Dose:	Start Date: (Month and Year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous Surgeries/Hospitalizations (include skin surgeries): NONE ☐

Type of Surgery/Hospitalization:	Reason:	Date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Do you currently smoke cigarettes? Yes ☐ No ☐ If so, how many per day? _____

Do you drink alcoholic beverages? Yes ☐ No ☐ If so, how many per day? _____

Review of Systems/Past Medical History:

Are you Hepatitis B or C positive? Yes ☐ No ☐ If so, which one, and have you been treated?_____

Are you HIV positive? Yes ☐ No ☐

Do you currently have, or have you ever had, problems with: (Please check yes or no only)

		Coordinator Notes:
Sleeping disorders		
Insomnia	Yes ☐ No ☐	_____
Narcolepsy	Yes ☐ No ☐	_____
Sleep Apnea	Yes ☐ No ☐ C-pap Yes ☐ No ☐	_____
Autoimmune		
Rheumatoid arthritis	Yes ☐ No ☐	_____
Lupus	Yes ☐ No ☐	_____
Fibromyalgia	Yes ☐ No ☐	_____
Cardiovascular		
Atrial Fibrillation	Yes ☐ No ☐	_____
Congestive heart failure	Yes ☐ No ☐	_____
High Blood pressure	Yes ☐ No ☐	_____
High Cholesterol	Yes ☐ No ☐	_____
Coronary artery disease	Yes ☐ No ☐	_____
Psychiatric/Neurologic		
Anxiety	Yes ☐ No ☐	_____
Depression	Yes ☐ No ☐	_____
Migraines	Yes ☐ No ☐	_____
Seizures	Yes ☐ No ☐ Last episode	_____
Endocrine/ Digestive		
Diabetes	Yes ☐ No ☐	_____
Thyroid Disease	Yes ☐ No ☐	_____
Night Sweats	Yes ☐ No ☐	_____
GERD	Yes ☐ No ☐	_____
Allergic		
Seasonal Allergies	Yes ☐ No ☐	_____
Anaphylaxis	Yes ☐ No ☐	_____
Skin		
Skin cancer	Yes ☐ No ☐ Type: Basal Cell Squamous Cell	_____
Melanoma	Yes ☐ No ☐ Location	_____
Eczema	Yes ☐ No ☐	_____
Rosacea	Yes ☐ No ☐	_____
Psoriasis	Yes ☐ No ☐	_____
Acne	Yes ☐ No ☐	_____
Other: _____		_____
_____		_____

Female Patients:

Date of last menstrual period: _____ (If exact date is unknown please enter approximate)

Method of Birth Control: _____ Surgically Sterile (Tubal Ligation, Hysterectomy) Date of procedure _____
_____ Natural Postmenopausal _____Depo Provera _____ Injection _____ Implant ____ Patch ____ Ring
_____ Oral Contraceptives _____ Vasectomized Partner _____ Condoms _____ Foam/Gel _____ Abstinence

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____

If patient did not qualify please list reason:_____

Notes:_____