# ***Clinical Research of South Nevada / Roger Estevez, MD***

4020 Pecos McLeod Rd Las Vegas, Nevada 89121
Phone: (702) 570-6107

## PATIENT DEMOGRAPHICS / MEDICAL HISTORY FORM

(The following information is very important to your health. Please take the time to fully and completely fill out both sides. This is important information and we are counting on you.)

*(The information provided in all the papers of this form is real and correct to the best of my knowledge.)*

Name: _____ Date of Birth: _____ Age: _____

Address:_____City_____ST_____ZIP_____

Home Phone: (____) _____-_____ Cellphone: (____) _____-_____ Sex: □F □M Occupation: _____

Last 4 SS #_____ E-Mail address: _____

Emergency Contact: _____ Relationship: _____ Telephone #:(____) _____-_____

Race: □White □Black/ African American □Asian □American Indian /Alaska Native □Fillip □Latino □Other(specify)_____

**Who is your Primary Care Physician?** _____ Phone: (_____) _____-_____

**Have you ever had any surgery?** If so, please specify:_____

_____

**Do you have any allergies** (ex: latex, etc)? _____

_____

**Prescription and Non-Prescription Medications you are currently taking:** (including aspirin, vitamins, birth control, herbs, etc.)

| Medication | Dose | How often? | Start Date | Stop Date | Indication |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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## SOCIAL HISTORY

Do you smoke? □Never □Yes □NO How many per day?____ When did you start smoking? _____ Quit date? _____

Do you drink alcohol? □Yes □No □ Occasionally If yes, how many/week? _____ How much_____

Substance abuse? □No □Yes What Type(s)? :_____

Is there any chance of you being Pregnant? □Yes □No Have you ever had any Sexually Transmitted Disease: □Yes □No

**Method of Birth Control**: □ Diaphragm/ spermicide □IUD □Oral Contraceptives (pills) □Condoms
□Hormonal Implant □Sponge □Surgical Sterilization(date):_____
□Otro:_____

□**Post-Menopausal for at least one year** □Yes □No Last Menstrual Period: _____

**Will you continue this method for the length of the Study and for at least 3 Month after completion of the Study?**
□**Yes** □**No** **Patient Initials**_____

How long ago was your last COLONOSCOPY completed?_____

Patient / Guardian Signature: _____ Date: _____

I'm Certify that all my Medical History Information that I have provided to C.R.O.S.N. is accurate and Current to the best of my Knowledge.

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# MEDICAL HISTORY/REVIEW OF SYSTEMS:

Have you been diagnosed with one or more of the following health problems? If so, specify:

**Please at least put the year when you start with**

| **CARDIOPULMONARY** | Start Date | Ongoing | **EYE, EAR, NOSE, AND THROAT** | Start Date | Ongoing |
|---|---|---|---|---|---|
| High blood pressure | | | Glaucoma | | |
| TIA | | | Cataracts | | |
| **Stroke / MI** | | | **ENDOCRINE** | Start Date | |
| Pacemaker | | | Thyroid problems | | |
| **STENT / PCI / CABG** | | | UTI(Urinary tract infection) | | |
| PAD ( Peripheral Arterial Disease) | | | Kidney Stone | | |
| Emphysema / COPD | | | Urinary retention | | |
| Asthma | | | Diabetic Neuropathy | | |
| Hypercholesterolemia | | | Diabetes: Type I | | |
| | | | Diabetes: Type II | | |
| **HEMATOLOGIC/IMMUNE SYSTEM** | Start Date | | **NEUROPSYCHIATRIC** | Start Date | |
| Clotting problem | | | Multiple Sclerosis | | |
| Lupus Autoimmune disease | | | Epilepsy / Seizure | | |
| Anemia / Leukemia | | | Frequent Headaches | | |
| Immune deficiency | | | Parkinson's | | |
| **GASTROINTESTINAL** | Start Date | | **MUSCULOSKELETAL & SKIN** | Start Date | |
| Constipation | | | Scoliosis | | |
| Hemorrhoids | | | Leg Cramps While Walking | | |
| Diverticulitis | | | Arthritis Rheumatoid | | |
| Cirrhosis / Pancreatitis | | | Osteoarthritis | | |
| Crohn's/Colitis | | | Psoriasis | | |
| Irritable bowel syndrome | | | Eczema | | |
| Heartburn/ Acid reflux disease | | | Fibromyalgia | | |
| Diarrhea | | | | | |
| **INFECTIOUS DISEASE** | Start Date | Ongoing | | | |
| | | | | | |
| AIDS/HIV | | | | | |
| Hepatitis A | | | | | |
| Hepatitis B | | | | | |
| Hepatitis C | | | | | |

Educational Level: ____Elementary ___Middle School ___ High School ___University other _____

**Do you anticipate any surgery within the next 6 months? □Yes □No When?_____**

**Do you have any reactions with anesthesia? _____**

**Do you have cancer? □Yes □No**

Type:_____ First diagnosed: _____ Treatment:_____

Patient / Guardian Signature: _____ Date: _____

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**FAMILY HISTORY:** Please check if any of your blood relative had any of the following health problems

| | Mother | Father | Brother/Sister | Son/Daughter | Grandparent(s) | Others |
|---|---|---|---|---|---|---|
| Asthma | | | | | | |
| High blood pressure | | | | | | |
| Diabetes | | | | | | |
| Epilepsy | | | | | | |
| Heart Attack | | | | | | |
| Stroke | | | | | | |
| Cancer | | | | | | |
| Other | | | | | | |

I certify that I am in all my faculties to authorize C.R.O.S.N. to do the "A1C test", now to check the last result if I want to participate in one of the clinical trials. _____
Initials

I'm not participating in any other Clinical Trial at any other Institution including C.R.O.S.N. If I have ever participated in other Clinical Trials, It has been > 30 days since completing the mentioned one. _____

I certify that my medical information that I have provided C.R.O.S.N. is true and actual to the best of my knowledge.

Patient / Guardian Signature: _____ Date: _____

I'm Certify that all my Medical History Information that I have provided to C.R.O.S.N. is accurate and Current to the best of my Knowledge.