# **MEDICAL HISTORY FORM**

## Study Name

|  |  |
| --- | --- |
| **Site ID:** **Participant ID:**  | **Date (dd/mmm/yyyy):** **Study Visit:**  |

### Body System Codes

|  |  |  |  |
| --- | --- | --- | --- |
| 01 = General Appearance02 = Gastrointestinal03 = HEENT04 = Neurological | 05 = Neck06 = Chest07 = Respiratory08 = Cardiovascular | 09 = Abdominal10 = Extremities11 = Integumentary12 = Genitourinary  | 13 = Musculoskeletal14 = Lymphatic15 = Other  |

| **Line** | **Description** | **Body System** (Use Code List) | **Start and Stop Dates**(dd-mmm-yyyy) | **Ongoing**(🗹 if Yes) | **Currently Treated with Medications**(🗹 if Yes) |
| --- | --- | --- | --- | --- | --- |
| 1 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 2 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 3 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 4 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 5 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 6 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 7 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 8 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 9 |  |  | Start Date Stop Date  | ☐ | ☐ |
| 10 |  |  | Start Date Stop Date  | ☐ | ☐ |

***\*Use additional pages as necessary***

**Completed by** (Signature):

**Date** (dd/mmm/yyyy):

*Version\_November 2020*

### Medical History Form Completion Instructions

* **Description:** Write a brief description of the participant’s medical history.
* **Body System:** Refer to the box labeled “Body System Codes” to select the body system that applies to the description
* **Start Date:** Record the Start Date in dd-mmm-yyyy format. The date should be recorded to the level of granularity known (e.g., year, year and month, complete date).
* **Stop Date:** If condition is **Ongoing**, leave the Stop Date blank and proceed to the Ongoing column. If condition is not **Ongoing**, record Stop Date in the dd-mmm-yyyy format. The date should be recorded to the level of granularity known (e.g., year, year and month, complete date).
* **Ongoing:** Only check the 🗹 if **Yes**, if condition is Ongoing, otherwise leave blank.
* **Currently Treated with Medications:** Only check the 🗹 if **Yes**, box if condition is currently treated with medications, otherwise leave blank.
* **Completed by**: Person who completes form signs it and records the date of his/her signature in dd-mmm-yyyy format