Today’s Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Please Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(First) (Middle) (Last)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street or P.O.Box) (Apt. No)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City, State) (Zip Code)

Is this your permanent residence? □Yes □No DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission to leave a message on the answering machine: □Yes □No (Initials)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check your responses to the following:**

|  |
| --- |
| □ Yes, I would like to receive appointment reminders and study correspondence via email and/or  text message to the cell phone number/email address I provided above. I understand I can  unsubscribe at any time.  □ Yes, I would like to receive information on new study openings via email and/or text message to  the cell phone I provided above. I understand I can unsubscribe at any time.  What is your preferred method of contact? □ email □ text □ phone call |

Gender: □Male □Female Marital Status: □Single □Married □Separated □Divorced □Widowed

Race: □White/Caucasian □Black/African American □Asian □American/Alaskan Native

□Native Hawaiian/Pacific Islander □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Background: □Hispanic/Latino □Non-Hispanic/Latino

Are you a diabetic: □ Yes □ No If yes: □ Type 1 □ Type 2

Emergency Contact or Caregiver: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name) (Telephone) (Relationship)

**Female participants, please complete:**

|  |
| --- |
| Is there any chance you are pregnant or could be? □Yes □No |
| Is **NO**, please specify □ Hysterectomy □ post-menopausal:  If post-menopausal, what was the year of last period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please Fill Out the Back of the Form!**

**Implanted electronic medical device**? □Yes □No

If yes, please specify the type of device: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours ago did you eat or drink anything other than water?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have permission to notify your Primary Care Physician of your results and study participation?

□Yes □No

Hospital of choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a previous research participant? □Yes □No

When and Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use:** Please be honest. This is a judgment-free zone.

Do you drink alcohol?  Yes  No

Number of alcoholic drinks a week: \_\_\_\_\_\_\_\_\_\_\_  Beer  Wine  Liquor

How many times in a year have you had greater than 3 drinks (for women) or greater than 4 drinks (for men) in a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing below, I certify that the above information is true and accurate to the best of my knowledge. I understand that I am being evaluated only for possible participation in a clinical research trial with Verity Health PNW and that this evaluation is not for diagnostic or treatment purposes. No formal diagnostic or treatment relationship with Verity Health PNW, I, or any of its staff is implied nor intended, nor is participation in any specific study promised or guaranteed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from further disclosing such information without the express written consent of the person to whom such information pertains, or as otherwise permitted by state law. Concerning HIV/AIDS, substance abuse, or psychiatric records, specific written consent is required – a general authorization for the release of medical information is NOT sufficient for this purpose.

|  |
| --- |
| **For the Technician to complete:**  **CTMS ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height\_\_\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI\_\_\_\_\_\_\_\_\_\_\_\_\_ B/P\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_** |
| **FibroScan:**  CAP Score: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stiffness Score (kPa): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IQR/Med: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |