# Vivid Clinical Research

## Medical Intake Form

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email Address: _____

DOB: _____ Age: _____ Height: _____ Weight: _____

Referred by: _____

| Yes | No | Have you had or still have? | Yes | No | Have you had or still have? |
|---|---|---|---|---|---|
| | | Diabetes | | | Stroke/TIA |
| | | High Blood Pressure | | | Parkinson's Disease |
| | | High Cholesterol | | | Seizures/Epilepsy |
| | | Thyroid Disease | | | Sickle Cell Disease |
| | | Kidney Problems | | | Cancer |
| | | Gallstones | | | Mental Illness |
| | | Dialysis | | | Alzheimer's/Dementia |
| | | Sleep Apnea | | | Stomach or Intestinal Ulcers |
| | | Asthma | | | Reflux Esophagitis/GERD |
| | | Heart Disease | | | Rheumatoid Arthritis |
| | | Pacemaker | | | Cirrhosis/Liver Disease |
| | | Defibrillator | | | Drug Addiction |
| | | Palpitations/Irregular Heartbeat | | | Alcohol Addiction |
| | | Arthritis | | | Erectile Dysfunction |

Do you have any Allergies or Sensitivities? Yes or No (circle one) *If yes please list medication and reaction below.*

| List Medications you are Allergic/Sensitive to | List Reaction when medication was taken |
|---|---|
| | |
| | |
| | |

**Females Only:**

Are you of childbearing potential? Yes or No (circle one)

Are you post-Menopausal (no menstrual cycle for 12 months)?

# Vivid Clinical Research

Name: _____

## Ocular and Medical Surgical History

| **Surgery** | **Date** | **Reason for Surgery** (Heart Attack, Knee Repair) |
|---|---|---|
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## Prior* and Current Medications

*(*Last 90 days)*

| **Medication Name** (Include Vitamins & Herbals) | **Dosage** | **Frequency** (Once, Twice, etc.) | **Reason for Taking** (Diabetes, Asthma, etc.) | **Start Date** | **Stop Date** |
|---|---|---|---|---|---|
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# Vivid Clinical Research

**Additional Medication Page # __**

Name: _____

## Prior* and Current Medications

*(*Last 90 days)*

| **Medication Name** (Include Vitamins & Herbals) | **Dosage** | **Frequency** (Once, Twice, etc.) | **Reason for Taking** (Diabetes, Asthma, etc.) | **Start Date** | **Stop Date** |
|---|---|---|---|---|---|
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