SEATTLE CLINICAL RESEARCH CENTER

633 Yesler Way | Seattle, WA 98104
p 206.522.3330 | f 206.522.8594
www.SeattleCRC.com

RESEARCH PARTICIPANT REGISTRATION FORM

PATIENT: _____
Legal Last Name Legal First Name M.I.

PREFERRED NAME: _____ DOB: _____/_____/_____ AGE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME/ MOBILE PHONE: _____ EMAIL: _____

SOCIAL SECURITY NUMBER # (Why are we asking for this?*): _____ - _____ - _____
IRS requires that businesses report all payments made to each person to whom have been paid at least $600 in other income for the course of one year on form **1099-MISC (Miscellaneous Income). Social Security # and current address are required to report.*

ARE YOU A STUDENT? ☐ Yes ☐ No *If yes*, NAME OF SCHOOL: _____

OCCUPATION: _____ EMPLOYER: _____

CHECK ALL OF THE FOLLOWING THAT APPLY:

OKAY TO LEAVE A DETAILED MESSAGE:
☐ on home # ☐ on mobile # ☐ at a different phone #:

OKAY TO LEAVE INFORMATION WITH:
☐ Relationship & Name: _____

OKAY TO LEAVE APPOINTMENT REMINDERS VIA:
☐ Phone Call ☐ Text Message ☐ Email

OKAY TO CONTACT YOU ABOUT UPCOMING RESEARCH STUDIES VIA:
☐ Phone Call ☐ Text Message ☐ Email

HOW DID YOU HEAR ABOUT US?
☐ Previous study participant ☐ Instagram
☐ Facebook ☐ Website
☐ Friend/Family: _____ ☐ Other: _____

EMERGENCY CONTACT
NAME: _____ RELATIONSHIP TO PATIENT: _____
HOME/ MOBILE PHONE: _____ WORK PHONE: _____

SIGNATURE: _____ **DATE:** _____

Seattle Clinical Research Center (SCRC) is a dedicated clinical trial investigative site. SCRC has successfully executed hundreds of multi-specialty Phase I-IV medical device and biopharma clinical trials since 1991 and has particular expertise in women's health-related drugs and medical devices as well as migraine and vaccine studies.

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INTAKE FORM

Please use black or blue ink & do NOT print double-sided

PATIENT (Legal Name): _____ DATE: _____
Last Name First Name M.I.

PREFERED NAME: _____ DOB: ____/____/____ AGE: _____

GENDER: ☐ MALE ☐ FEMALE ☐ OTHER _____ PREFERRED PRONOUNS: _____

RACE: _____ ETHNICITY: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

PRIMARY CARE: _____
Name Address Phone

PHARMACY: _____
Name Address Phone

Are you currently participating in any other clinical trials here or at another location? ☐ Yes ☐ No

MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Dermatological (Skin)	**NONE ☐**				
Precancer/Cancer: ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Melanoma ☐ Other: _____	Now ☐ In the past ☐				
Hives ☐ Chronic ☐ Intermittent	Now ☐ In the past ☐				
Eczema	Now ☐ In the past ☐				
Psoriasis	Now ☐ In the past ☐				
Acne	Now ☐ In the past ☐				
Rosacea	Now ☐ In the past ☐				
☐ Lichen Sclerosus or ☐ Lichen Planus	Now ☐ In the past ☐				
Other skin conditions: _____	Now ☐ In the past ☐				
Neurological (Nervous system)	**NONE ☐**				
Migraines / Headaches ☐with Aura	Now ☐ In the past ☐				
Depression	Now ☐ In the past ☐				
Anxiety	Now ☐ In the past ☐				
Psychiatric Care/ Hospitalization	Now ☐ In the past ☐				
Suicide Attempt and/or Ideation	Now ☐ In the past ☐				
Epilepsy/Seizures	Now ☐ In the past ☐				
ADD/ ADHD	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				

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Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Cardiovascular (Heart & blood)	**NONE ☐**				
Heart Murmur	Now ☐ In the past ☐				
Irregular Heart Rate/Palpitations	Now ☐ In the past ☐				
Obesity (BMI >30)	Now ☐ In the past ☐				
Heart Attack	Now ☐ In the past ☐				
High Blood Pressure	Now ☐ In the past ☐				
Elevated Cholesterol	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Pulmonary (Lungs)	**NONE ☐**				
Asthma	Now ☐ In the past ☐				
COPD	Now ☐ In the past ☐				
Persistent Cough	Now ☐ In the past ☐				
Severe COVID-19 Infection	Now ☐ In the past ☐				
Tuberculosis ☐ Active ☐ Latent	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Gastrointestinal (Digestion)	**NONE ☐**				
Ulcers - Type:_____	Now ☐ In the past ☐				
Hepatitis Type: ☐ A ☐ B ☐ C	Now ☐ In the past ☐				
Liver Problems	Now ☐ In the past ☐				
Gall Bladder Disease - Type:_____	Now ☐ In the past ☐				
Heartburn/GERD	Now ☐ In the past ☐				
Chronic Constipation	Now ☐ In the past ☐				
Diarrhea	Now ☐ In the past ☐				
Persistent: ☐ Nausea ☐ Vomiting	Now ☐ In the past ☐				
Blood in Stool	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Urologic (Kidneys & Bladder)	**NONE ☐**				
Frequent Urinary Tract Infection	Now ☐ In the past ☐				
Kidney Infection	Now ☐ In the past ☐				
Kidney Disease	Now ☐ In the past ☐				
Bladder Problems (check all applicable) ☐ Incontinence (leaking) ☐ Urinary Frequency ☐ Urinary Urgency	Now ☐ In the past ☐				
Blood in Urine	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Musculoskeletal(Muscles& Bones)	**NONE ☐**				
☐ Osteoporosis or ☐ Osteopenia	Now ☐ In the past ☐				
Arthritis - Type: _____	Now ☐ In the past ☐				
Fibromyalgia	Now ☐ In the past ☐				
Fractures - Type: _____	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Eyes, Ear, Nose, Throat	**NONE ☐**				
Glaucoma ☐ L ☐ R Type: _____	Now ☐ In the past ☐				
Hearing Problems ☐ L ☐ R	Now ☐ In the past ☐				
Seasonal Allergies	Now ☐ In the past ☐				
Cataracts ☐ L ☐ R	Now ☐ In the past ☐				
Current major dental issues	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Endocrine (Glands)	**NONE ☐**				
Diabetes Mellitus Type ☐ 1 or ☐ 2	Now ☐ In the past ☐				
Thyroid Disease: ☐ Hyper or ☐ Hypo	Now ☐ In the past ☐				
Polycystic Ovary Syndrome (PCOS)	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Hematology (Blood Disorders)	**NONE ☐**				
Anemia	Now ☐ In the past ☐				
Blood Clots/Pulmonary Embolism	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Immune Disorders	**NONE ☐**				
Lupus/ SLE	Now ☐ In the past ☐				
HIV/ AIDS	Now ☐ In the past ☐				
Celiac Disease	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Cancer (non-skin)	**NONE ☐**				
Cancer Type: _____	Now ☐ In the past ☐				
Cancer Type: _____	Now ☐ In the past ☐				
Genital Infections/ STI's	**NONE ☐**				
Human Papilloma Virus (HPV)	Now ☐ In the past ☐				
Yeast Infection	Now ☐ In the past ☐				
Bacterial Vaginosis (BV)	Now ☐ In the past ☐				
Herpes: ☐ T1 - Oral ☐ T2 - Genital	Now ☐ In the past ☐				
Chlamydia	Now ☐ In the past ☐				
Gonorrhea	Now ☐ In the past ☐				
Other: _____	Now ☐ In the past ☐				
Female Reproductive	**NONE ☐**				
Uterine fibroids	Now ☐ In the past ☐				
Endometriosis	Now ☐ In the past ☐				
Ovarian Cyst ☐ L ☐ R	Now ☐ In the past ☐				
Vaginal Dryness	Now ☐ In the past ☐				
Hot Flashes/ Vasomotor symptoms	Now ☐ In the past ☐				
Decreased Sex Drive	Now ☐ In the past ☐				
Painful intercourse	Now ☐ In the past ☐				
Irregular Bleeding	Now ☐ In the past ☐				
Painful Periods	Now ☐ In the past ☐				
Other: _____.	Now ☐ In the past ☐				

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Male Reproductive	**NONE ☐**				
Prostate Problems	Now ☐ In the past ☐				
Decreased Sex Drive	Now ☐ In the past ☐				
Erectile Dysfunction	Now ☐ In the past ☐				
Other: _____.	Now ☐ In the past ☐				
Other	**NONE ☐**				
Fainting/dizziness with blood draws	Now ☐ In the past ☐				
Latex or adhesive sensitivity	Now ☐ In the past ☐				
Insomnia	Now ☐ In the past ☐				
Sleep Apnea	Now ☐ In the past ☐				
Other: _____.	Now ☐ In the past ☐				
Other: _____.	Now ☐ In the past ☐				

GYNECOLOGICAL HISTORY

Sexually Active? Y / N	Current Birth Control:	Start Date:
Age of first menstrual period:	Last menstrual period:	
My menses last _____ days and comes every _____ days _____Heavy _____Medium _____Light		
Date of last Pap:	If any abnormal paps, when and how was it treated:	
Last Mammogram:	Where:	
If any abnormal mammograms and when:		
Breast procedures/ Ultrasound/ MRI:		

OBSTETRIC HISTORY (PREGNANCY)

Date	Type of Delivery	Complications of Pregnancy

OTHER PREGNANCIES- MISCARRAGES/ ABORTIONS/ ECTOPICS

Date	Outcome

PERSONAL HEALTH HABITS

Marital Status: Single ☐ Partnered ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐
Tobacco use: Y / N Average amount per day: _____ Year began: _____ Year quit: _____
Alcohol use: Y / N Average number of drinks per week: _____
Current or history of substance abuse: Y / N Substance: _____ Year began: _____ Year quit: _____

DRUG / FOOD ALLERGIES

Medication or Food	Reaction	Date you first had this reaction

CURRENT MEDICATIONS

Medications you are taking currently *(include those you buy at the drug store, health food store)*						
Medications, Vitamins, and/or Health supplements	**Dose** (e.g. 10mg)	**Form** (e.g. Tablet, Cream)	**How often?** (e.g. twice a day)	**Start Date**	**Stop Date** (If applicable)	**Reason taken** (e.g. cholesterol)
Other Medications you have taken in the past 3 months						

IMMUNIZATIONS

Yearly flu shot: Y / N	If Yes, Last flu shot date:
Measles/Mumps/Rubella vaccine Varicella vaccine (or had chicken pox)	Y / N Y / N
If age 65 or over, pneumococcal vaccine	Y / N
Ever been tested for TB Was it positive? BCG vaccine (TB vaccine)	Y / N Y / N Y / N
Series of vaccines for HPV (Human Papilloma Virus)	Y / N ☐ First vaccine ☐ Two vaccines ☐ All three vaccines
Date of last tetanus shot *(recommended every 10 years)*	_____

COVID–19 Vaccine? Y / N *Please record the four (4) most recent doses only*

Dose 1 Date: _____ Manufacturer: _____
Dose 2 Date: _____ Manufacturer: _____
Dose 3 Date: _____ Manufacturer: _____
Dose 4 Date: _____ Manufacturer: _____

SURGICAL HISTORY

Surgery Type	**Date(s)**	**Reason**	**Where was it done?** ***(Hospital/City)***

FAMILY MEDICAL HISTORY

Relative	**Still Alive?**	**Major Medical Problems (**i.e. Stroke, DVT, Heart attack, Cancer, Diabetes, Hypertension**)**
Mother	**Y / N**	
Father	**Y / N**	
Sibling	**Y / N**	
Sibling	**Y / N**	
Sibling	**Y / N**	
Other	**Y / N**	

Patient Signature: _____ **Date:** _____

Reviewed by Provider: _____ **Date:** _____

Reviewed by CRC: _____ **Date:** _____

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MAP AND DIRECTIONS

From 1-5 (North & South)

North:
1. Get on I-5 S from NE 45th St.
2. Take exit 165A towards James St.
3. Keep right onto 6th Ave.
4. In 500 feet, turn left onto Yesler Way
5. Take an immediate right (70 ft) into our parking lot and park into one of our "SCRC Participants" spots.
6. Once you enter our building, take the elevator to our 2nd floor to check-in at our front desk.

South:
1. Get on 1-5 N
2. Take exit 164A from 1-5 N
3. Take 6th Ave to Yesler Way for 0.6 miles.
4. Take an immediate right into our parking lot. Park into one of our "SCRC Participants" spots.
5. Once you enter our building, take the elevator to our 2nd floor to check-in at our front desk.

Via Seattle Metro Transit

1. Plan your trip at https://kingcounty.gov/en/dept/metro
2. Once you enter our building, take the elevator to our 2nd floor to check-in at our front desk.

From Seattle Transit Link Station

- **Pioneer Square Station**
    1. Once you exit the Pioneer Square Station Link station, Head southeast on 3rd Ave toward James St.
    2. Turn left onto Yesler Wy
    3. Turn right when you see the sign for Seattle Clinical Research Center.
    4. Once you enter our building, take the elevator to our 2nd floor to check-in at our front desk.

- **International District Station**
    1. Once you exit the Int'l Dist/Chinatown Link station, continue north on 5th Ave towards S Jackson St.
    2. Turn right on to S Washington St
    3. You will see a staircase at the end of S Washington St to your left. Take the stairs up to our building
    4. Once you enter our building, take the elevator to our 2nd floor to check-in at our front desk

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PARKING MAP

The map below has been created to display available parking spots. The spaces marked 'SCRC Participant'are reserved for patients coming to our office. Unassigned parking spots are first come first serve. Street Pay to park, maybe available, but has a 2-hour maximum.