

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/CONTACT YOU ABOUT UPCOMING STUDIES VIA:

☐ Phone Call ☐ Text Message ☐ Email

WERE YOU REFERRED BY ANOTHER STUDY PARTICIPANT?

☐ Yes, participant name: _____ ☐ No

PRIMARY CARE PHYSICIAN NOTIFICATION

Please initial below whether you want us to notify your doctor of your participation in this study:

_____ Yes, I want the Study Doctor to inform my primary care physician of my participation in this study.

_____ No, I do not want the Study Doctor to inform my primary care physician of my participation in this study.

_____ I do not have a primary care physician.

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

HOME/ MOBILE PHONE: _____ WORK PHONE: _____

SIGNATURE: _____ DATE: _____

INTAKE FORM

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

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

PREFERRED 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 <input type="checkbox"/>				
Precancer/Cancer: <input type="checkbox"/> Basal cell carcinoma <input type="checkbox"/> Squamous cell carcinoma <input type="checkbox"/> Melanoma <input type="checkbox"/> Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hives <input type="checkbox"/> Chronic <input type="checkbox"/> Intermittent	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Eczema	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Psoriasis	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Acne	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Rosacea	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<input type="checkbox"/> Lichen Sclerosus or <input type="checkbox"/> Lichen Planus	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other skin conditions: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Neurological (Nervous system)	NONE <input type="checkbox"/>				
Migraines / Headaches <input type="checkbox"/> with Aura	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Depression	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Anxiety	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Psychiatric Care/ Hospitalization	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Suicide Attempt and/or Ideation	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Epilepsy/Seizures	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
ADD/ ADHD	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

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 a particular expertise in women's health-related drugs and medical devices as well as migraine and vaccine studies.

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

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

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

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 <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/>
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 <i>(include those you buy at the drug store, health food store)</i>						
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	Y N
Varicella vaccine (or had chicken pox)	Y N
<i>If age 65 or over, pneumococcal vaccine</i>	Y N
Ever been tested for TB	Y N
Was it positive?	Y N
BCG vaccine (TB vaccine)	Y N
Series of vaccines for HPV (Human Papilloma Virus)	Y N <input type="checkbox"/> First vaccine <input type="checkbox"/> Two vaccines <input type="checkbox"/> All three vaccines
Date of last tetanus shot <i>(recommended every 10 years)</i>	_____
COVID-19 Vaccine? Y / N <i>Please record the four (4) most recent doses only</i>	
Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ Dose 4 Date: _____	Manufacturer: _____ Manufacturer: _____ Manufacturer: _____ 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: _____

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.

PARKING MAP

The map below has been created to display available parking spots. The spaces marked 'SCRC Participant' and 'Seattle CRC' are reserved for patients coming to our office. Please try to use these spots during your visit.

