ACRC TRIALS
Today's Research. Tomorrow's Medicine.

New Patient Paperwork

Please complete this paperwork in its entirety.

Personal Information

Full name:	
Nickname:	
Home address:	
Home phone:	
Mobile or cellular phone:	☐ Allow Text messages
Email Address:	
Sex ☐ Male ☐ Female	
Birthday (MM/DD/YYYY):	Age:
SSN:	
Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native American or Alaskan Native	
Marital Status:	
How did you hear about us?	
Currently enrolled in another research study? ☐ Yes ☐ No	
Do we have your consent to request your medical records?	☐ Yes ☐ No
Do we have your consent to include you in our research database?	☐ Yes ☐ No
If Female, Are you or do you think you are pregnant?	☐ Yes ☐ No
Are you planning or attempting to get pregnant?	☐ Yes ☐ No
What type of birth control are you using?	____________
Are you post-menopausal?	☐ Yes, age of onset:___ ☐ No

Emergency and/or Guardian contact information

Emergency or Guardian Contact person:
Emergency or Guardian phone number:
Emergency or Guardian email:

Vaccinations

Have you received a COVID-19 vaccine? ☐ Yes ☐ No
If yes, date of last dose:
Have you received a Flu (influenza) vaccine? ☐ Yes ☐ No
If yes, date of last dose:

Family Medical History

☐ No significant family history is known.

Include any significant medical history for each family member.

☑	Condition	Family Member (s)
	Heart Disease/Attack	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Stroke	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Diabetes (Specify:______________	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	High Blood Pressure	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	High Cholesterol	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Thyroid Disease	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Depression	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Other Mental Illness (Specify:______________	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Alcoholism	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Asthma	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Osteoporosis	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Migraines	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Cancer (Specify:_____________)	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF
	Other, specify:_____________)	☐ Mother ☐ Father ☐ Brother ☐ Sister ☐ Child ☐ MGM ☐ MGF ☐ PGM ☐ PGF

Prior/ Current Medications

Include any medications and/or vaccines received in the last 3 months. **Year is mandatory.**

Medication	Indication (Reason)	Dose	Dose (units)	Frequency	Medication Start Date

Medical History

Year is mandatory.

☑	Condition	Date of Diagnosis	☑	Condition	Date of Diagnosis
	Abnormal pap smear			Frequent Sinus Infections	
	Acne			Gallstones	
	ADD/ADHD			Glaucoma	
	Alcohol /Drug Abuse			Gout	
	Allergies (Seasonal or Medication-Specify: ___________)			Heart Condition (Specify:_____________________)	
	Anemia			Headaches/ Migraines	
	Angina			Heart Attack	
	Anxiety/ Depression			Herpes	
	Arthritis Specify: ______________________			Hepatitis: (Specify A, B or C: ____________)	
	Asthma			High Blood Pressure	
	Bipolar Disorder			High Cholesterol	
	Blood Clot or disorders (Specify:_____________________)			Immunodeficiency (HIV or Specify:_____________________)	
	Cancer (Specify:_____________________)			Kidney Disease(Specify:______________)	
	Cardiac Disease (Specify:_____________________)			Melanoma or Other skin cancer (Specify:_____________________)	
	Colon Polyps			Kidney Stones	
	Chron's Disease or IBS			Lupus	
	COPD			Kidney Infections	
	Chronic Bronchitis			Osteoarthritis	
	Colon Polyps			Osteopenia	
	Diabetes (Specify: ___________________)			Neurologic condition: (Specify: _____________________)	
	Diverticulitis			TB or Positive TB test	
	Ulcerative Colitis			Prostate Problems	
	Earaches			Psoriasis	
	Eating Disorders			Osteoporosis	
	Eczema			Reflux (Heartburn)/ Ulcers	
	Emphysema			Rheumatoid Arthritis	
	Frequent UTIs			Seizures	
	CVA /Stroke			STD (Specify: _________________)	
	Thyroid Disease (Specify)			Warts or Other Skin conditions	

Hospitalization History **Year is mandatory.**

Type of Admission (ER, ICU, Planned, etc)	Reason/Indication	Date(s)

Surgical History

Please include reason for surgery under Medical History. **Year is mandatory.**

☑	Procedure	Reason/ Indication	Date(s)	☑	Procedure	Reason/ Indication	Date(s)
	Appendectomy				Heart Surgery (Specify)		
	Arthroscopy				Hemorrhoids		
	☐ Back or ☐ Neck surgery				Hernia (Specify)		
	Cataract Surgery				Hysterectomy		
	☐ Tonsillectomy/ ☐ Adenoidectomy				☐ Knee or ☐ Hip Replacement		
	Gall Bladder Removal				☐ Mastectomy or ☐ Lumpectomy		
	Polyp Removal (Colon)				☐ Tubal Ligation/ ☐ Vasectomy		
	Cesarean Section				Other: ______________		
	Plastic Surgery				Other: ______________		

Social History

History of Smoking:	☐ Former (Date quit:_______)	☐ Current (Start Date:_________**)**	☐ Never
		Packs per day:	
Recreational Drug Use:	☐ Former (Date quit:___)	☐ Current (Start Date:_________)	☐ Never
Alcohol Use:	☐ Former (Date quit:_______)	☐ Current (Start Date:_________)	☐ Never
Caffeine Use:		☐ Former ☐ Current	☐ Never
Sexually Transmitted Disease:		☐ Yes, ___________________________	☐ No
Recent Travel outside the US:		☐ Yes, ___________________________	☐ No
Occupation:			

I confirm the above information is complete and if any new information comes about, I will inform the research team:

____ ____________________

Patient Signature **Date**

ACRC TRIALS MEDICAL RECORDS RELEASE

PATIENTS: Please indicate the coordinator's name on the fax.

To: ______________________ Date: ______________________

____

Physician or Hospital Name

City, State ______________________

Phone Number ______________________

Fax Number ______________________

I hereby authorize and request that you release my complete medical record and the following specific reports (if available):

✓ **Medical Summary Page / Most Recent Clinic Visit**

Other:____

Patient Information

First Name: ______________________ Last Name: ______________________

SS#: ______________________ DOB: ______________________

Address (Street, City, State, Zip): ____

Patient Signature: ____

Date: ____

Please send this information to:

ACRC Trials

Attention: Clinical Research Coordinator

5655 W. Spring Creek Pkwy, Suite 125, Plano, TX 75024

☎ 972-354-1520

- ☐ **Fax Number: (972) 692-7713**
  - West Plano Medical Village – Family Practice
  - West Plano Medical Village – Pediatrics
  - West Plano Medical Village – Dermatology
  - Frisco Medical Village – Family Practice
- ☐ **Fax Number: (972) 692-7913**
  - Independence Medical Village – Family Practice
  - Medical City Plano – Family Practice
- ☐ **Fax Number: (469) 574-7822**
  - Carrollton Regional Family Center - Family Practice
  - Grapevine - Pediatric Dermatology
- ☐ **Fax Number: (512) 532-6801**
  - Southwest Medical Village – Family Practice