RESEARCH INSTITUTE OF DALLAS PARTICIPANT SCREENING QUESTIONNAIRE

For your convenience in the participant screening process, you can print and complete the questionnaire below and bring it with you to your initial office visit. If you have questions, please call our office at 214-265-2137. ***Your information will remain confidential and will help us to evaluate your eligibility to become a clinical research study participant.***

First Name: _____Last Name: _____

Email address: _____Daytime Phone Number:_____

Cell Phone Number:_____Evening Phone Number:_____

Mailing address: Street or P.O.Box _____

City: _____State:_____ZIP Code:_____

Date of Birth: _____Age:_____Height:_____Weight:_____

PLEASE LIST ALL CURRENT HEALTH CONDITIONS OR DISEASES AND THE DATE OF DIAGNOSIS FOR EACH:
(e.g., diabetes, high cholesterol, osteoporosis, high blood pressure, etc.)

DIAGNOSIS/CONDITION	**DATE OF DIAGNOSIS**
1._____	_____
2._____	_____
3._____	_____
4._____	_____

PLEASE LIST ALL MEDICATIONS TAKEN DAILY, THE DATE YOU BEGAN EACH ONE AND THE AMOUNT YOU TAKE EACH DAY:

MEDICATION:	**START DATE**	**TOTAL DAILY AMOUNT**
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____

Please provide any additional health or medication information on the back of this form.

If you wish to send the form by fax, please include both sides**.** Our fax number is: 214-265-2164. If you choose to mail it to us at our office address, please do so right away so that we might receive it well in advance of your appointment date. ***We thank you for your interest in R.I.D.***