

Medical History (a)

STUDY NAME

Site Number: 002

Pt_ID: bm 9KP

Visit Date:

01 / 002 / 2017
d d m m m y y y y

Visit Type: ☒ Screening

☐ Baseline

Does the participant have a medical or surgical history, current or resolved, of any of the following?

MEDICAL HISTORY	Yes / No	Unknown	If Yes, Explain	Current / Resolved
1. Head, Eye, Ear, Nose, Throat	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
2. Respiratory	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
3. Cardiovascular	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
4. Gastrointestinal	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
5. Genitourinary	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
6. Musculoskeletal	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
7. Neurological	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
8. Endocrine-Metabolic	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
9. Blood/Lymphatic	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
10. Dermatologic	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<u>eczema</u>	<input type="checkbox"/> Current <input checked="" type="checkbox"/> Resolved
11. Psychiatric	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
12. Allergy	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
13. Other, specify: _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved

(Note: If this CRF is used as a source document, it must be signed and dated by study personnel.)