

# Medical History (a)

## STUDY NAME

Site Number: 001

Pt\_ID: xJ10mL1

Visit Date:

07 / 00 / 20 / 17  
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Chronic asthma	<input checked="" 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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>		<input type="checkbox"/> Current <input type="checkbox"/> Resolved
11. Psychiatric	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	OCD, Major Depressive Disorder	<input checked="" 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.)