Charter Research

To help us prepare for your visit, please complete the Prescreen Paperwork below.

You have a few options:

1. **Fill Out the Form on Your Computer and Email to Charter**
   - This form is fillable, so you can type directly into it.
   - After completing it, save the form to your computer.
   - Then, email it to us at: prescreenpaperwork.tv@charterresearch.com
   - You may also print and bring the form with you if you do not want to email it.

2. **Print, Fill Out, and Bring the Form With You**
   - You can print the form, fill it out by hand, and bring it to your appointment.

If you have any questions or need help, feel free to contact us 352-441-2000.

We look forward to seeing you at your appointment!

Charter Research

PATIENT DEMOGRAPHICS

First Name	Last Name	Middle Initial
Address		
City	**State**	**Zip Code**
Main Phone No.	**Cell Phone No.**	**Email**
Date of Birth: ____/____/_____	**Age:**	**Sex:** ☐ Male ☐ Female

Ethnicity (Select one): ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race (Select one or more): ☐ White ☐ Black or African American ☐ Asian

☐ Native Hawaiian or Other Pacific Islander ☐ Native American or Alaskan Native

PRIMARY CARE PHYSICIAN INFORMATION

Physician Name		
Address		
City	**State**	**Zip Code**
Main Phone No.	**Fax No.**	**Last Exam Date:** ____/____/_____

IN CASE OF EMERGENCY

Name of Local Friend/Relative	Relationship to Patient
Phone No.	

OFFICE USE ONLY

The above information is true to the best of my knowledge. I authorize Charter Research to collect, review, and store my information for future reference and to contact me regarding clinical trials.

_____

Patient/ LAR Signature **Date**

_____

Coordinator Signature **Date**

Charter Research

Date: _____

Name: _____ **DOB:** _____

Medical History Form

Please review these health conditions/diseases*, check* ***"YES" or "NO"*** *as they relate to your health and provide the year.*

Years are required – if the exact year is unknown, an estimated year is acceptable.

Your Health	YES	NO	START YEAR	END YEAR
PULMONARY:				
Asthma				
COPD/Emphysema				
Chronic Bronchitis				
Sleep Apnea / Do you use a ☐ CPAP ☐ BiPAP				
Other Pulmonary:				
CARDIOVASCULAR:				
Coronary Artery Disease/Heart Disease				
Heart Attack **(Myocardial Infarction)**				
Percutaneous Coronary **(Stent)**				
Coronary Artery Bypass Surgery				
Congestive Heart Failure				
Atrial Fibrillation				
Stroke/Cerebral Vascular Disease				
Peripheral Artery Disease				
Hypertension **(High Blood Pressure)**				
Hypercholesterolemia **(High Cholesterol)**				
Hyperlipidemia **(High Triglycerides)**				
Other Cardiovascular:				

Your Health	YES	NO	START YEAR	END YEAR
METABOLIC/ENDOCRINE:				
Thyroid Disease: Choose One				
Diabetes: Type I				
Diabetes: Type 2				
Obesity				
Other Metabolic/Endocrine:				
AUTOIMMUNE:				
Lupus				
Rheumatoid Arthritis				
Sjogren Syndrome				
Myasthenia Gravis				
Multiple Sclerosis **(MS)**				
Grave's Disease				
Hashimoto Thyroiditis				
Gout				
Other Autoimmune:				
DERMATOLOGY:				
Psoriasis				
Eczema				
Skin Cancer: Basal Cell Carcinoma				
Skin Cancer: Squamous Cell Carcinoma				
Skin Cancer: Melanoma				
Other Dermatology:				
MUSCOLOSKELETAL:				
Osteoarthritis **(Location):**				
Chronic Back Pain				
Osteopenia				
Osteoporosis				
Fibromyalgia				
Other Musculoskeletal:				

Your Health	YES	NO	START YEAR	END YEAR
GASTROINTESTINAL:				
Ulcers				
Gastroesophageal Reflux **(GERD)**				
Ulcerative Colitis				
Crohn's Disease				
Fatty Liver Disease **(MAFLD)**				
Hepatitis A, B or C				
Pancreatitis				
Gallbladder Disease **(Gallstones)**				
Other Gastrointestinal:				
Genitourinary:				
Post-Menopausal ☐ N/A				
Chronic Urinary Infections				
Hematuria **(Blood in urine)**				
Kidney Disease – Stage:				
Kidney stones				
Erectile Dysfunction ☐ N/A				
Overactive Bladder				
Benign Prostatic Hyperplasia **(Enlarged Prostate)**				
Other Genitourinary:				
Neurological:				
Alzheimer's Disease				
Dementia				
Memory Loss				
Peripheral Neuropathy				
Parkinson's Disease				
Migraines/Headaches				
Depression				
Anxiety				
Bipolar Disorder				
Insomnia				
Post Traumatic Stress Disorder				
Seizure Disorder – last episode:				
History of Seizure – last episode:				
Other Neurological:				

Your Health	YES	NO	START YEAR	END YEAR
HEENT:				
Glaucoma				
Seasonal allergies				
Macular Degeneration: Choose One				
Diabetic Retinopathy				
Cancer:				
Location:				
Family History:				
Alzheimer's Disease				
Dementia				
Memory Loss				
Cardiovascular Disease				

Surgical History

SURGERY NAME	SURGERY YEAR
Appendectomy	
Prostatectomy	
Cholecystectomy *(gallbladder removal)*	
Partial Hysterectomy	
Total Hysterectomy	
Tubal Ligation	
Traumatic Injury	
Pacemaker/Defibrillator	
Spinal Stimulator	
Bladder/Bowel Stimulator	
Mastectomy	
Lumpectomy	
Other surgeries:	

ALCOHOL:

☐ None

If yes, check all that apply:

☐ Wine, how many glasses: _____ ☐ daily ☐ weekly ☐monthly ☐occasionally

☐ Hard alcohol, how many drinks: _____ ☐ daily ☐ weekly ☐ monthly ☐occasionally

☐ Beer, how many: _____ ☐ daily ☐ weekly ☐ monthly ☐occasionally

SMOKING/NICOTINE:

☐ None

If yes, check all that apply:

☐ Cigarettes, Number of packs: _____ ☐ daily ☐ weekly ☐ monthly ☐ occasionally

☐ Other tobacco, nicotine: _____ ☐ daily ☐ weekly ☐ monthly ☐ occasionally

If you are not currently smoking, have you ever smoked? ☐ No If yes, when did you stop? _____.

Current Medications

Medications (includes Rx/OTC)	Indication (reason why taken)	Dose	START YEAR