Medical History (a)

STUDY NAME

Site Number: _____

Pt_ID: _____

Visit Date:

__ __ / __ __ __ / __ __ __ __
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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	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
2. Respiratory	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
3. Cardiovascular	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
4. Gastrointestinal	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
5. Genitourinary	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
6. Musculoskeletal	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
7. Neurological	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
8. Endocrine-Metabolic	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
9. Blood/Lymphatic	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
10. Dermatologic	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
11. Psychiatric	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
12. Allergy	☐ Yes ☐ No	☐		☐ Current ☐ Resolved
13. Other, specify: _____	☐ Yes ☐ No	☐		☐ Current ☐ Resolved

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