

If you are interested in participating in future research studies with Clinical Research Advantage, please complete the information listed below.

NAME _____ DATE OF BIRTH ____/____/____ AGE _____

MAILING ADDRESS _____

CITY, STATE, ZIP CODE _____

HOME PHONE _____ WORK/CELL PHONE _____ PRIMARY DR. _____

E-MAIL ADDRESS _____ GENDER: MALE FEMALE

CURRENT MEDICAL CONDITIONS, (Check all that apply)

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Diabetic Foot Ulcer	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Acne	<input type="checkbox"/> Diabetic Neuropathy	<input type="checkbox"/> Obesity/Weight Loss
<input type="checkbox"/> Allergies (Seasonal)	<input type="checkbox"/> Eczema	<input type="checkbox"/> Osteoarthritis (general)
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Enlarged Prostate	<input type="checkbox"/> Osteoarthritis (Knee)
<input type="checkbox"/> Anxiety Disorders	<input type="checkbox"/> Erectile Dysfunction / Impotence	<input type="checkbox"/> Osteoarthritis (Hip)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> BPH (Benign Prostate Hyperplasia)	<input type="checkbox"/> Headaches	<input type="checkbox"/> Overactive Bladder
<input type="checkbox"/> Birth Control Studies	<input type="checkbox"/> Cluster Headache	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> PMS
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Tension Headache	<input type="checkbox"/> Post Menopausal
<input type="checkbox"/> COPD / Emphysema	<input type="checkbox"/> Healthy Patient Studies	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Constipation	<input type="checkbox"/> Heartburn / GERD / Acid Reflux	<input type="checkbox"/> Pulmonary Hypertension
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Restless Leg Syndrome
<input type="checkbox"/> Dementia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia / Sleep Disorder	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Diabetes Type I Type II	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Urinary Incontinence
Medication: _____	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Vaccine Studies (flu, shingles, etc.) for children, adults, and seniors
Medication: _____	<input type="checkbox"/> Low Libido	
Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Benefits of participating in a research study vary, but usually include:

- Study related medical evaluations and medication are provided at no charge to the study participant
- Monetary reimbursement for your time and travel

Requirements of a research study vary, but usually include:

- Additional visits (usually brief) for safety reasons and to evaluate the medication
- Some diary keeping or note taking

By signing this form I am allowing entry of the above personal medical history to be entered into the data bank of Clinical Research Advantage in order that I may be contacted regarding participating in future research studies. This information is considered confidential and will not be distributed in any manner. I have the right to ask to be removed from the data bank at any time.

Signature

Date

Please fax completed form to 480-820-5521 or mail it to: Clinical Research Advantage
2141 E. Broadway Road, Suite 110
Tempe, AZ 85282