# Medical History (a)

**STUDY NAME**

**Site Number:**

**Pt\_ID:**

**Visit Date:**

 / /    .

 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**
 | Checkbox. YesCheckbox. No | Checkbox. |   | Checkbox. CurrentCheckbox. Resolved |
| 1. **Respiratory**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Cardiovascular**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Gastrointestinal**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Genitourinary**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Musculoskeletal**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Neurological**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Endocrine-Metabolic**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Blood/Lymphatic**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Dermatologic**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Psychiatric**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Allergy**
 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |
| 1. **Other, specify:**

 | Checkbox. YesCheckbox. No | Checkbox. |  | Checkbox. CurrentCheckbox. Resolved |