# Medical History (a)

**STUDY NAME**

**Site Number:**

**Pt\_ID:**

**Visit Date:**

/ /    .

d d m m m y y y y

**Visit Type:** Checkbox. **Screening** Checkbox. **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. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Respiratory** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Cardiovascular** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Gastrointestinal** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Genitourinary** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Musculoskeletal** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Neurological** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Endocrine-Metabolic** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Blood/Lymphatic** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Dermatologic** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Psychiatric** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Allergy** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |
| 1. **Other, specify:** | Checkbox. Yes Checkbox. No | Checkbox. |  | Checkbox. Current Checkbox. Resolved |