Draft

CTRIC Contact Sheet

Demographics

RPN# ________

Site: 1 2 3 4 5 6 . 7 8

Date __ / __ / ____   Sub. initials ___   Subject # ___

Shade Circles Like This--> ●
Not Like This--> ⊗ ✓

Please use blue or black ink only

Please use all caps when filling out form

Screening Number: SCREEN - ___

Group # ○ 1 ○ 2 ○ 3 ○ 4

Last Name | First Name | MI

Street Address (Home)

City | State | Zip Code

Phone Number (___) ___ - ____

Age

Date of Birth __ / __ / ____

Or leave message at: (___) ___ - ____

email address

Last Name of person to be contacted in case of emergency: | First Name | Relationship to you:

Street Address of emergency contact:

City | State | Zip Code | Phone Number (___) ___ - ____

How did you hear about CTRIC?

Have you ever done other studies? ○ Y ○ N If yes, where?

Ethnicity (choose one): ○ Hispanic or Latino ○ Not Hispanic or Latino

Gender: ○ Male ○ Female

Citizenship

Race: (choose all that apply)

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Black or African American
- ○ White / Caucasian
- ○ Fill in here if you do not wish to provide some or all of the above information.

Marital Status: *Choose one* ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated

Current Status: *Choose one* ○ Student ○ Employed ○ Unemployed ○ Other, specify:

Years of Education: ☐☐ Degrees Obtained:

Military Experience: ○ Yes ○ No If YES, did your deploy during Desert Storm/Desert Shield or have been stationed in SW Asia/Korea since 1990? ○ Yes ○ No

Comments on Military Experience: _____

Height: ☐☐ . ☐☐ ft in Weight: ☐☐☐ lbs BMI: ☐☐

Do you have any allergies? ○ Y ○ N If so, what are they?

Are you currently taking any medications? ○ Y ○ N If yes, which ones?

Are you currently under the care of a doctor? ○ Y ○ N If yes, for what?

Do you have any history of any chronic diseases? ○ Y ○ N If yes, what?

If you are a female of child bearing potential, what type of birth control (if any) do you use?

I have received the University of MD - UPI Notice of Privacy Practices ○ Y ○ N

_____ Date ☐☐ / ☐☐ / ☐☐☐☐

Signature of Volunteer

_____ Date ☐☐ / ☐☐ / ☐☐☐☐

Signature of Witness

CTRIC Staff Only - Volunteer has signed & received a copy of HIPAA authorization ○ Y ○ N initials: _____ date: _____

ID checked ○ Y ○ N type QC'd _____ Date: _____

Surgery ○ Y ○ N type

Travel ○ Y ○ N type

Volunteer may be contacted in the future as indicated on the CTRIC Database HIPAA Authorization form?
○ Yes ○ No