The Washington Center for Weight Management & Research
2800 S. Shirlington Rd., Suite 505 Arlington, VA 22206 703.807.0037 703.807.0038 fax

To determine if you are eligible for one of our research studies complete the questions below. Please note this is protected health information. You do not have to answer any questions you do not want to. Your answers will be kept confidential being used only for study screening purposes. The information collected will be destroyed if you do not give your permission to keep it in a database.

Name: _____ Date: _____

Address: _____ __
_____
_____

Telephone: (please check the # we can leave a message at)
(___) _____ (day) ☐
(___) _____ (night) ☐
(___)_____(cell) ☐

E-mail: _____

Medical History:

Age: _____ Gender: (M / F)
Date of Birth: _____
Height: _____ Weight: _____

Current & Prior Medications:

(List any medications or supplements (including anything taken over the counter / herbals) that you *currently* take **or** have *previously* taken within the last year, the reason for taking them, and dates you started or stopped them.)

_____
_____
_____
_____
_____
_____
_____
_____

Have you had any dose changes in the past 6 months of the above medications: _____
Do you have any drug allergies:_____
_____
Have you had any surgeries or procedures?_____
_____
_____

Are you capable of having children? Y / N
If YES, are you willing to use contraception? _____
Please indicate any contraception currently using: _____
_____

For *Women* only: are you pregnant / nursing or plan to become pregnant? _____

If NO, indicate the reason and date:
__ Hysterectomy (date: _____)
__ Vasectomy (date: _____)
__ Post-menopausal (date of last menses :_____)
__ Tubal ligation (date: _____)

Do you have a *history* of, or *currently* have any of the following conditions:

YES|NO If Yes, please specify and indicate date of diagnosis)
___ | ___ Diabetes?
___ | ___ Heart Disease? (heart attack, arrhythmia, angina etc
___ | ___ Neurological Disorder (stroke, neuropathy, tremor etc)
___ | ___ Cancer?
___ | ___ High Blood Pressure?
___ | ___ Kidney disease?
___ | ___ Liver disease?
___ | ___ Thyroid or other endocrine disease / hormone problem?
___ | ___ Mental Health related issue? (depression, anxiety, bipolar disease, etc)
___ | ___ Seizure disorder or head injury?
___ | ___ AIDS / HIV +?
___ | ___ Any other chronic condition?

If yes to any of the above, please specify and include dates of diagnosis, procedures and any pertinent information:_____
_____
_____
_____
_____
_____

Where did you hear about our research studies?
☐ The Express ☐ Washington Examiner
☐ Radio Ad ☐ Washington Post
☐ Dr. Referral _____
☐ Patient Referral _____
☐ Website ☐ Flier
☐ Other: _____