TANDEM Clinical Research
1111 Medical Center Blvd, SuiteN502
Marrero, LA 70072
504-934-8424

Intake Form

Demographic Information

Name: _____ Date of Completion: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other, Specify: _____

Marital Status: _____ Highest Level of Education: _____ Occupation: _____

Patient Contact Information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

What is the best time of Day to Contact You? _____

Emergency Contact

Primary Emergency Contact Name: _____ Phone: _____

Secondary Emergency Contact Name: _____ Phone: _____

Primary Care Physician Information

Primary Care Physician or Office Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Office Number: _____ Fax Number: _____

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Tobacco History
Have you ever Smoke Tobacco Products? ☐ Yes ☐ No
Type of Tobacco Product(s): _____
If Yes, Amount per Day: _____ # of Years Smoked: _____
Are you still smoking? ☐ Yes ☐ No If no, when did you quit? _____

Alcohol History
Have you ever consumed alcohol? ☐ Yes ☐ No
Type of Alcohol: _____
If Yes, Amount Consumed per Day: _____ # of Years Consumed: _____
Are you still consuming alcohol? ☐ Yes ☐ No If no, when did you quit? _____

Allergies
☐ **None**

Food/Drug Allergy	Start Date	Reaction
	☐ Birth or ☐ Onset Date: _____	
	☐ Birth or ☐ Onset Date: _____	
	☐ Birth or ☐ Onset Date: _____	
	☐ Birth or ☐ Onset Date: _____	

Family History

Diagnosis	Family Member(s)
Heart Disease / Heart Attack	
Diabetes Type I or II	
Asthma	
Dementia	

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Review of Body Systems		
Please indicate if you have any of the following:		
Eyes	**Start Date**	**Stop Date or Ongoing**
☐ Cataracts ☐ Right ☐ Left	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Macular Degeneration	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Glaucoma	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Diabetic Retinopathy	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Ear, Nose, and Throat	**Start Date**	**Stop Date or Ongoing**
☐ Seasonal Allergies or Allergic Rhinitis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Impaired Hearing	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Chronic Sinusitis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Respiratory	**Start Date**	**Stop Date or Ongoing**
☐ Asthma	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Chronic Bronchitis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ COPD	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Emphysema	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Chronic Pneumonia	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Sleep Apnea ☐ Use CPAP	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Tuberculosis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Cardiovascular	**Start Date**	**Stop Date or Ongoing**
☐ Angina (Chest Pain)	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Heart Murmur	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Heart Attack	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Irregular Heart Beat (Atrial Fibrillation)	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ High Blood Pressure	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ High Cholesterol / Lipids	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Coronary Artery Disease	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Congestive Heart Failure	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Peripheral Vascular Disease	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing

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Gastrointestinal	Start Date	Stop Date or Ongoing
☐ Acid Reflux / GERD	____/____/____	____/____/____ Or ☐ Ongoing
☐ Ulcers	____/____/____	____/____/____ Or ☐ Ongoing
☐ Hernia Type:_____	____/____/____	____/____/____ Or ☐ Ongoing
☐ Gastric Polyps	____/____/____	____/____/____ Or ☐ Ongoing
☐ Hemorrhoids	____/____/____	____/____/____ Or ☐ Ongoing
☐ Diverticulitis	____/____/____	____/____/____ Or ☐ Ongoing
☐ Irritable Bowel Syndrome	____/____/____	____/____/____ Or ☐ Ongoing
☐ Non-Alcoholic Fatty Liver	____/____/____	____/____/____ Or ☐ Ongoing
☐ Chronic Constipation	____/____/____	____/____/____ Or ☐ Ongoing
☐ Chronic Diarrhea	____/____/____	____/____/____ Or ☐ Ongoing
☐ Gallstones	____/____/____	____/____/____ Or ☐ Ongoing
Endocrine / Metabolic	**Start Date**	**Stop Date or Ongoing**
☐ Diabetes Mellitus Type: _____	____/____/____	____/____/____ Or ☐ Ongoing
☐ Hypoglycemia (Low Blood Sugar)	____/____/____	____/____/____ Or ☐ Ongoing
☐ Hyperthyroidism (Overactive)	____/____/____	____/____/____ Or ☐ Ongoing
☐ Hypothyroidism (Underactive)	____/____/____	____/____/____ Or ☐ Ongoing
☐ Thyroid Nodule	____/____/____	____/____/____ Or ☐ Ongoing
☐ Gout	____/____/____	____/____/____ Or ☐ Ongoing
☐ Vitamin Deficiency Type: _____	____/____/____	____/____/____ Or ☐ Ongoing
Hematologic	**Start Date**	**Stop Date or Ongoing**
☐ Clotting Disorder	____/____/____	____/____/____ Or ☐ Ongoing
☐ Chronic Anemia	____/____/____	____/____/____ Or ☐ Ongoing
Immunologic	**Start Date**	**Stop Date or Ongoing**
☐ HIV/AIDS	____/____/____	____/____/____ Or ☐ Ongoing
☐ Lupus	____/____/____	____/____/____ Or ☐ Ongoing
☐ Cancer Type: _____	____/____/____	____/____/____ Or ☐ Ongoing

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Hepatic	Start Date	Stop Date or Ongoing
☐ Liver Disease	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Hepatitis A, B, or C Type: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Renal	**Start Date**	**Stop Date or Ongoing**
☐ Kidney Stones	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Recurrent Kidney Infections	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Chronic Kidney Disease	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Urogenital / Gynecologic	**Start Date**	**Stop Date or Ongoing**
☐ Overactive Bladder	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Uterine Fibroids	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Uterine Cysts	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Endometriosis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Erectile Dysfunction	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Benign Prostate Hypoplasia (BPH)	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing

Males Method of Contraception: ☐ NA, Female
☐ Vasectomy ☐ Condoms/Spermicide ☐ Abstinence ☐ Sterile Partner ☐ None ☐ Other: _____

Females Reproductive History: ☐ NA, Male
Are you currently Pregnant, Lactating, or Breast Feeding? ☐ Yes ☐ No

Please specify: # of pregnancies: _____ # of Live Births: _____
# of C-Sections: _____ with dates: _____ / _____ / _____, _____ / _____ / _____

Check all reproductive procedures you have received:
☐ Bilateral Tubal Ligation, Date: ____ / ____ / _____ ☐ Partial Hysterectomy, Date: ____ / ____ / _____
☐ Complete Hysterectomy, Date: ____ / ____ / _____ ☐ Bilateral Oophorectomy, Date: ____ / ____ / _____
☐ Uterine Ablation, Date: ____ / ____ / _____ ☐ IUD Placement, Date: ____ / ____ / _____
☐ Contraceptive Implant Placement, Date: ____ / ____ / _____

When was your last Menstrual Period? _____ / _____ / _____
If no longer having Menstrual Periods, was this Spontaneous or due to a procedure? ☐ Spontaneous ☐ Procedure

Current Method of Contraception:
☐ Surgically Sterile ☐ Postmenopausal ☐ Oral Contraceptives ☐ Transdermal Patch Contraceptive ☐ IUD
☐ Contraceptive Implant ☐ Condoms/Spermicide ☐ Abstinence ☐ Sterile Partner ☐ None
☐ Other: _____

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Musculoskeletal	Start Date	Stop Date or Ongoing
☐ Broken Bones Location: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Osteoarthritis Location: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Rheumatoid Arthritis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Fibromyalgia	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Neck/Back Pain Reason: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Shoulder Pain Reason: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Hip Pain Reason: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Knee Pain Reason: _____	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Psychiatric	**Start Date**	**Stop Date or Ongoing**
☐ Anxiety or Panic Attacks	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Depression	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Bipolar Disorder	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Neurologic	**Start Date**	**Stop Date or Ongoing**
☐ Insomnia	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Migraine Headaches	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Chronic Headaches	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Seizure Disorder	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Stroke / TIA	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Alzheimer's Disease	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Dementia	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Diabetic Peripheral Neuropathy	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Post-Herpetic Neuralgia (PHN)	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
Skin	**Start Date**	**Stop Date or Ongoing**
☐ Psoriasis	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing
☐ Eczema	_____ / _____ / _____	_____ / _____ / _____ Or ☐ Ongoing

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Surgical History		
Surgery	**Date**	**Reason for Surgery**
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	

Do you anticipate or expect surgery in the next year? ☐ Yes ☐ No
If yes, please specify surgery/reason: _____

Any Other Medical Conditions		
Diagnosis	**Date**	**Stop Date or Ongoing**
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	
	_____ / _____ / _____	

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Prescription Medications				
Medication	**Current Dose**	**How Often**	**Start Date**	**Taken for What**
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
Over the Counter Medications				
Medication	**Current Dose**	**How Often**	**Start Date**	**Taken for What**
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	
			_____ / _____ / _____	

Patient Signature: _____ Date: _____ / _____ / _____

CRC/Investigator Signature: _____ Date: _____ / _____ / _____