Registration Form for Clinical Research Studies

PATIENT INFORMATION:
First name: ______________________________
Last name: ______________________________
Address: ______________________________
____
City: ______________________________
State: ______________________________
Zip code: ______________________________
Home phone: ______________________________
Work phone: ______________________________
Date of birth: ______________________________

Have you ever been a patient at an Advanced Healthcare location?
(Check one) Yes No

Have you ever been a patient at a Columbia St. Mary's Hospital or clinic?
(Check one) Yes No

Medical conditions (please check all that apply):

- ❑ Acne
- ❑ Allergies
  - ❑ Please list: ______________________________
    ____
    ____
- ❑ Arthritis – Osteo
- ❑ Arthritis – Rheumatoid
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cancer
  - ❑ Special type: ______________________________
- ❑ Diabetes (treatment with diet or exercise)
- ❑ Diabetes (treatment with pills or insulin)
- ❑ Eczema / Dermatits
- ❑ Gastrointestinal disorders (specify type)
- ❑ Heart disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hives
- ❑ Irritable Bowel Syndrome
- ❑ Migraine headaches
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Psoriasis
- ❑ Rosacea
- ❑ Sexual Dysfunction
- ❑ Other:
  - ❑ Please list: ______________________________
    ____
    ____

- ❑ I authorize the above information to be included in Advanced Healthcare's and Columbia St. Mary's Clinical Research Database. I am aware that Advanced Healthcare and Columbia St. Mary's will not release this information to any outside sources.

If you wish to mail or fax the registration form to us, please send it to:
Advanced Healthcare
ATTN: Clinical Research Center
3003 W. Good Hope Road
Milwaukee, WI 53209