

DERMATOLOGY RESEARCH CENTER, INC.
Leonard J. Swinyer, M.D., FAAD, CPI
3920 South 1100 East, Suite 210
Salt Lake City, Utah 84124
801-269-0135

If I qualify for this study, I authorize Dr. Leonard Swinyer and his research team to use or disclose my personal health information for research purposes when such research has been approved by an institutional review board that has reviewed the research to ensure the privacy of my personal health information, or as otherwise allowed by law. Most research studies include a number of researchers, businesses and government agencies that may have access to my personal health information. They may include, but are not limited to, the study Sponsor, FDA, Department of Health and Human Services (DHHS), the governing institutional review board (IRB), clinical research organization (CRO), quality assurance personnel and laboratories. This authorization will never expire unless and until you revoke (cancel or withdraw) it.

| | |
|---|------------------------------|
| Signature of Subject (parent/legally authorized representative if under 18) | Date |
| Office use only... | Protocol Number: _____ |
| Subject Initials: _____ | Screening/Subject No.: _____ |

CONFIDENTIAL SUBJECT INFORMATION

| | | | |
|--|---|--|---|
| SUBJECT IDENTIFICATION – Please print clearly | | | |
| Subjects full name | | Parent/LAR/Spouse name | |
| Address | City | State | Zip |
| Sex (M/F): Male Female | | Birthdate (M/D/Y): | Age: |
| Telephone Numbers: | | | |
| Home: | | Work: | Cell: |
| Email: | | | |
| Ethnicity | | Race | |
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Not of Hispanic origin | <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Other: _____ |

| | |
|--|--------------|
| PERSON TO BE NOTIFIED IF ABOVE CANNOT BE LOCATED – Please print | |
| Full name | Relationship |
| Telephone Number | |

How did you hear about this study? radio newspaper flyer other: _____

Are you a clinic patient of Dr. Swinyer's office? Yes No

Would you like to be informed of future research projects? Yes No

PLEASE COMPLETE OTHER SIDE

CURRENT MEDICATIONS

List all medications and supplements you are currently taking/using:

None

| Medication name | Daily dose | Start Date | Reason taking/using |
|-----------------|------------|----------------|---------------------|
| | | ____/____/____ | |
| | | ____/____/____ | |
| | | ____/____/____ | |
| | | ____/____/____ | |
| | | ____/____/____ | |
| | | ____/____/____ | |
| | | ____/____/____ | |

MEDICAL HISTORY

Have you had or do you now have any conditions of the following body systems:

| System | Check one | If Yes, briefly describe and give dates |
|-----------------------------------|--|---|
| Eyes | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Ears/Nose/Throat | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Cardiovascular (heart) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Respiratory (lungs) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Stomach / Intestines | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Hepatic (liver) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Genitourinary | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Renal (kidney) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Neurologic | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Psychiatric | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Endocrine (thyroid/diabetes) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Hematologic (blood) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Musculoskeletal (bones/arthritis) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Dermatologic (skin) | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Allergies | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Alcohol / Drug Abuse | No <input type="checkbox"/> Yes <input type="checkbox"/> | |

For office use only...

Subject enrolled in study? Yes No If "No", list reason: _____