

DERMATOLOGY RESEARCH CENTER, INC.
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The reason we collect your personal information is to demonstrate to our study sponsors, and other governing agencies that Dermatology Research Center, Inc. is screening actual individuals for participation in research. By screening for this study, you authorize Dermatology Research Center, Inc to use or disclose your 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 your personal health information, or as otherwise allowed by law. You will ordinarily not be identified by name in the study records. However, the Sponsor and its consultants will have the right to see your complete study records, including your name, and may choose to do so. Most research studies include a number of researchers, businesses and government agencies that may have access to your personal health information relating to this study. This authorization will never expire unless and until you revoke it in writing.

I have read and agree to the above paragraph:

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 print ad flyer internet 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: _____