|  |  |
| --- | --- |
| SPONSOR | PROTOCOL |
| PI: SITE#: | SUBJECT ID: |

**Medical History**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Body System** | **Diagnosed condition?** | **Diagnosis/Condition/Surgery** | **Onset Date**  **Or Year** | **Current Problem** |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |
| [insert body system] | Yes  No |  |  | Yes  No |

**ADDITIONAL NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MEDICAL HISTORY OBTAINED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**