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| **Part I: General Medical History** |
| Ask participant the following questions. If response is **YES**, indicate the associated body system number from Part II where the description can be found and describe in Part II. If response is **NO,** the remainder of this form should still be completed. |
|  | **No** | **Yes 🡪** (associated body system)  | **Comments** |
| 1 | Does the participant have any health problems? |[ ]  [ ]  **🡪** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 2 | Has the participant ever been hospitalized for any reason other than giving birth?  |[ ]  [ ]  **🡪** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 3 | Has the participant ever had surgery, including a hysterectomy? |[ ]  [ ]  **🡪** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 4 | In the past year, has the participant been to the emergency room? |[ ]  [ ]  **🡪** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 5 | Has the participant had any medical or health problems in the past year? |[ ]  [ ]  **🡪** ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

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| **Part II: Body System Medical History** |
| Ask if the participant ever experienced any significant medical problems involving the following organ/systems. If response is YES, include onset and outcome dates (if not resolved at baseline, mark “ongoing”), severity grade, medications taken, and any comments relevant to the diagnosis/description, and document on the Medical History Log CRF.  |
| **#** | **Body System** | **No** | **Yes** | **Onset Date** | **Outcome Date** | **Severity Grade** | **Med. Taken?** | **Description/Comments** |
| 1 | Head, eyes, ears, nose, or throat (HEENT) |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 2 | Prostate |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 3 | Lymphatic (processes involving lymph nodes) |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 4 | Cardiovascular (heart) |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| **Part II: Body System Medical History** |
| Ask if the participant ever experienced any significant medical problems involving the following organ/systems. If response is **YES**, include onset and outcome (if resolved) dates, severity grade, medications taken, and any comments relevant to the diagnosis/description. |
| **#** | **Body System** | **No** | **Yes** | **Onset Date** | **Outcome Date** | **Severity Grade** | **Med. Taken?** | **Description/Comments** |
| 5 | Respiratory (lungs) |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 6 | Liver |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 7 | Renal (bladder, kidney) |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 8 | Gastrointestinal |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 8 | Musculoskeletal (including bone fractures) |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 9 | Neurologic |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 10 | Skin |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 11 | Endocrine (hormones)/Metabolic |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 12 | Hematologic |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 13 | Cancer |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 14 | Alcohol / Recreational Drug Use |  |  |  | [ ]  ongoing |  |  |  |
| 15 | STI/RTI (HPV, HSV, GC/CT, Syphilis, Trichomoniasis, Candidiasis, PID) |  |  |  | [ ]  ongoing |  |  |  |
| 16 | OB/GYN (genital bleeding not associated with menses or childbirth, uterine fibroids, abnormal PAP, genital infection, hysterectomy) |  |  |  | [ ]  ongoing |  |  |  |
| 17 | Are there any other health issues? |  |  |  | [ ]  ongoing |  |  |  |
| **Part II: Body System Medical History** |
| Ask if the participant ever experienced any significant medical problems involving the following organ/systems. If response is **YES**, include onset and outcome (if resolved) dates, severity grade, medications taken, and any comments relevant to the diagnosis/description. |
| **#** | **Body System** | **No** | **Yes** | **Onset Date** | **Outcome Date** | **Severity Grade** | **Med. Taken?** | **Description/Comments** |
| 14 | Drug Allergy |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 15 | Other Allergy |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 16 | Mental Illness |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 17 | Ulcerative Colitis or Crohns Disease |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |

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| **Part III: Genital Symptoms** |
| Have you ever experienced or are currently experiencing any anogenital symptoms/diagnoses? |
| **#** | **Genital Symptoms** | **No** | **Yes** | **Onset Date** | **Outcome Date** | **Severity Grade** | **Med. Taken?** | **Description/Comments** |
| 1 | Anal or genital sores or ulcers | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 2 | Dysuria or urethral burning |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
| 3 | Anal pain | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 4 | Anorectal Bleeding | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| **Part III: Genital Symptoms/Diagnoses** |
| Have you ever experienced or are currently experiencing any anogenital symptoms/diagnoses? |
| **#** | **Genital Symptoms** | **No** | **Yes** | **Onset Date** | **Outcome Date** | **Severity Grade** | **Med. Taken?** | **Description/Comments** |
| 5 | Anal or rectal abscesses | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 6 | Urethral or anal discharge | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 7 | Anal or genital warts  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 8 | Anal fissures  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 9 | Hemorrhoids  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 10 | Urinary tract infection | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 11 | Excessive anal itching | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| 12 | Excessive flatulence  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |

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| **Part III: Genital Symptoms: Females Only** |
| Have you ever experienced any significant medical problems involving the following organ system/disease?  |
| **#** | **Body System** | **No** | **Yes** | **Onset Date** | **Outcome Date** | **Severity Grade** | **Med. Taken?** | **Description/Comments** |
|  | Genital/vaginal warts  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Pelvic inflammatory disease  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Abnormal pap smear  | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
| In the past 3 months have you experienced any of the following genital symptoms?  |
|  | Genital/vaginal burning | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Genital sores |[ ]  [ ]  |  | [ ]  ongoing |  |  |  |
|  | Genital/vaginal itching | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Genital/vaginal pain during sex | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Post-coital bleeding (bleeding after sex) | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Genital/vaginal pain not during sex | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Abnormal genital/vaginal discharge | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Unusual genital/vaginal odor | [ ]  |[ ]   | [ ]  ongoing |  |  |  |
|  | Dysuria (burning with urination) | [ ]  |[ ]   | [ ]  ongoing |  |  |  |