MICHIGAN CENTER FOR SKIN CARE RESEARCH
PARTICIPATING IN A CLINICAL RESERCH STUDY

- Thank you for your interest in a clinical research study through Michigan Center for Skin Care Research. Your participation - provides an opportunity for you to access investigational treatment options before they become widely available; allows you to play an active role in your own healthcare; and provides the sense of satisfaction to help other people who share your condition.

- The role of the site staff is to check your health at the beginning of the clinical study, provide specific instructions and guidance for what to do during the course of the study, watch over your health throughout the study and to make sure that the study protocol is followed.

- Based on your condition, some clinical trials involve more diagnostic tests, visits, or questionnaires than you might not initially expect. These tests, visits and questionnaires help the site staff, and the sponsor of the trial, assure that your health and safety are monitored as well as collect valuable information to help drive the investigational drug to market.

- Subjects in a clinical research study may be asked to elaborate on related health conditions which may make you feel vulnerable. We can assure you all of the information obtained during a clinical research study is kept secure and is shared with only those in relation to the sponsor of the clinical study. You as a subject are identified by your initials and a number that is assigned via a computer.

- Your participation is completely voluntary. If you decide to enroll in a study, you are free to leave the trial at any time for any reason.

For more information, please visit:
www.skincareresearch.com
or call us at (586) 286-7325

DISEASE: _____ **SKIN CARE RESEARCH REGISTRATION FORM** **SCR SCREEN #:** _____

CONSTANT CONTACT: ____ **PATIENT #:** _____

MIDWEST PHYSICIAN: _____

SCR USE:

Today's Date: _____ Midwest Center for Dermatology Patient**:** □Yes □ No Chart **#:**_____ □ EMA Note

PERSONAL DATA

Name: _____ _____ _____
Last First Middle

Address: _____Apartment # _____

_____
City State Zip

Home #_____**Work #**_____**Cell #**_____

May we leave a message at: □ Home □ Work □ Cell □ With family member?_____
Name

Employer:_____**Occupation**:_____

Birth Date:_____ Current Age:_____
Month, Day, Year

Sex at Birth: □Male □ Female Height: _____ Weight:_____

Marital Status: □ Single □ Married □ Widow □ Divorced

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race: □ White / Caucasian □ Black / African American □ Asian □ Other: _____

HOW DID YOU HEAR ABOUT US? _____ □ Recruitment Recorded

- **Are you currently participating in any research studies?** □ Yes □ No
- **Have you participated in any previous research studies with Skin Care Research?** □ Yes □ No
- **Would you like to receive text messages and emails about future studies?** □ Yes □ No
- **I wish to remain in the Skin Care Research database for future studies:** □ Yes □ No

Your Email address: _____

EMERGENCY DATA:

Please list the name and number of someone we can contact in case of emergency:

Name: _____Phone: _____Relationship: _____
First, Last

DISEASE: _____ **SKIN CARE RESEARCH REGISTRATION FORM** **SCR SCREEN #:** _____

CONSTANT CONTACT: ____ **PATIENT #:** _____

MIDWEST PHYSICIAN: _____

Name: _____ _____ _____
Last First Middle

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA):

We may review your database medical records occasionally to determine whether you may be eligible to participate in certain research studies. Only our clinicians, employees or other members of our workforce will review your medical record. None of your protected information will be disclosed to third parties without your specific authorization. We will contact you by email, text message, mail or any other form of recruitment.

I acknowledge that I have received a copy of the Dermatologists of Central States Notice of Privacy: Version - August 25, 2021.

Subject Signature: _____ **Date** ____/____/____

Parent/Guardian Signature: _____ **Date** ____/____/____
(Signature required if subject is less than 18 years of age)

Address (if different than patient's): _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

SKIN:

When you are exposed to sun do you:

□ Type I - (White) - Always Burns Easily, Rarely Tans
□ Type II - (White) - Always Burns Easily, Tans Minimally
□ Type III - (White) - Burns Moderately, Tans Gradually
□ Type IV – (White) - Burns Minimally, Always Tans Well
□ Type V – (Brown) - Rarely Burns, Tans Profoundly
□ Type VI – (Black) - Never Burns, Deeply pigmented (Insensitive)

Have you ever had skin cancer? □Yes □ No If yes, what type? _____

Has anyone in your family had a skin cancer? □Yes □ No If yes, who and what type? _____

Has anyone in your family had a malignant melanoma? □Yes □ No If yes, who? _____

SMOKER / ALCOHOL / RECREATIONAL DRUGS:

Do you smoke cigarettes? □ Yes □ No If yes, how many packs per day? _____ How long? _____

Do you smoke e-cigarettes? □ Yes □ No If yes, how many per day? _____ How Long? ____

Do you smoke a pipe? □ Yes □ No If yes, how often? _____ How long? _____

Do you chew tobacco? □ Yes □ No If yes, how often? _____ How long? _____

Do you drink alcohol? □ Yes □ No If yes, how much per day: Beer _____ Wine _____ Liquor _____

Do you use IV drugs? □ Yes □ No If yes, what? _____ How often? _____

Do you use recreational drugs? □ Yes □ No If yes, what? _____ How often? _____

DISEASE: _____ **SKIN CARE RESEARCH REGISTRATION FORM** **SCR SCREEN #:** _____

CONSTANT CONTACT: ____ **PATIENT #:** _____

MIDWEST PHYSICIAN: _____

Name: _____ _____ _____
Last First Middle

ALLERGIES:

List all allergies including environment, food, dyes, and medications or check: □ None / Does Not Apply

Medications
□ No □ Yes,
Type of Reaction / Year _____

_____

Environmental (Dust, Mold, Pollen, Mites, etc.)
□ No □ Yes,
Type of Reaction / Year _____

_____

Food
□ No □ Yes,
Type of Reaction / Year _____ -

_____

Other
□ Yes □ No
Type of Reaction / Year _____

_____

FOR WOMEN ONLY: Contraception/Sexuality

Date of last menstrual period: _____

□ Abstinence	□ Diaphragm	□ Spermicide
□ Cervical Cap	□ Foam Gel	□ Tubal ligation
□ Condom Only	□ Hysterectomy	□ Vaginal Condom
□ Condom/Spermicide	□ IUD	□ Withdrawal
□ Contraceptive Implant	□ Menopause	□ Not in sexually active relationship
□ Contraceptive Injection	□ Oral Contraceptive Pill	□ Other _____
□ Contraceptive Patch	□ Partner had Vasectomy	□ None

MEDICATIONS:

Are you using and/or taking any prescription medication, birth control, over the counter medications, vitamins, herbal remedies, and/or holistic measures?

□ Yes □ No

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MIDWEST PHYSICIAN: _____

SKIN CARE RESEARCH
MEDICAL HISTORY & MEDICATIONS

Name: _____ _____ _____
Last First Middle

MEDICAL CONDITION / SURGERY HISTORY:

Please list all medical conditions that you have and any surgeries that you have had done with the approximate date.

MEDICAL CONDITION / SURGERY HISTORY	APPROXIMATE DATE

PRESCRIPTION MEDICATIONS / OVER THE COUNTER MEDICATIONS - VITAMINS – SUPPLEMENTS:

Please list all oral, injectable, topical medications, vitamins & supplements.

MEDICATION	REASON FOR TAKING	DOSE	HOW OFTEN?	APPROX. DATE STARTED