SKIN CARE RESEARCH
REGISTRATION FORM

SCR SCREEN#_____

PATIENT#_____

DRUG#_____

SCR Use

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

PERSONAL DATA

Name _____ _____ _____
Last First Middle Initial

Permanent Address _____ Apartment # _____

_____
City State Zip

Home Phone # _____ Work #_____ Cell #_____

May we leave a message at: □ *home* □ *work* □*cell* □ *With which family member?* _____
Phone Number

Would you like to receive text messages about future studies? □ Yes □ No

Your Email address: _____

Employer_____ Occupation_____

Birth date_____ Current Age_____
Month, Day, Year

Sex at birth □Male □ Female Height_____ Weight_____ Social Security #_____

Marital Status □ Single □ Married □ Widow □ Divorced Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

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

Are you currently participating in any research studies? □ Yes □ No
Have you participated in any previous research studies with Skin Care Research? □ Yes □ No

EMERGENCY DATA

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

Name _____ Phone _____ Relationship _____
First, Last

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 Michigan Center for Skin Care Research Notice of Privacy: Version September 23, 2013.

_____ _____
Patient/Authorized Signature Date

I wish to remain in the *Skin Care Research* database for future studies: □ YES □ NO

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 #**_____

SKIN CARE RESEARCH
REGISTRATION FORM

SCR SCREEN#_____

PATIENT#_____

DRUG# _____

Name_____ **Birth date**_____ **Today's Date**_____

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 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?_____

ALLERGIES

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

ALLERGIES **WHAT KIND OF REACTION / DATE OR YEAR OCCURRED**

□ Yes □ No **Medications**_____

□ Yes □ No **Environmental (Dust, Mold, Pollen, Mites, etc.)** _____

□ Yes □ No **Food** _____

□ Yes □ No **Other** _____

FOR WOMEN ONLY - Date of last menstrual period: _____/_____/_____

CONTRACEPTION / SEXUALITY - Check primary birth control method used

□ 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.

Please check one: □ YES □ NO

SKIN CARE RESEARCH
Medical History & Medications

Medical History:

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

Medical Condition / Surgery	Date

Medications:

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

Medication	Reason for Taking	Dose	How Often?

Name:

_____

Primary Care Physician/Specialist Notification Option

Please check (√) below to indicate whether you want us to notify your primary care physician or specialist of your participation in this study.

☐ Yes, I want the study doctor to inform my primary care physician / specialist of my participation in this study. If yes, please provide us with the following information:

_____

Name of Primary Care Physician or Specialist

_____

Address

_____

City *State* *Zip*

_____

Telephone Number

☐ No I do not want the study doctor to inform my primary care physician / specialist of my participation in this study.

☐ I do not have a primary care physician / specialist.

☐ The study doctor is my primary care physician / specialist.

Name of Participant (Subject/Patient)_____
(Please Print)

Signature of Participant (Subject/Patient)_____Date_____

Parent/Guardian Signature_____Date_____
(Signature required if participant/subject/patient is a minor or unable to sign)

Witness_____Date_____

Study/Protocol #_____ Subject #_____

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