Date:_____

Sneeze, Wheeze, & Itch Associates
2010 Jacobssen Drive, Normal Il 61761
309-452-0995
www.asthma2.com

Volunteer Information

Welcome to Sneeze, Wheeze, & Itch Associates. Please complete this form so we may learn more about you and your health. All information is kept confidential and is used to evaluate your participation in a clinical research study.

Last Name	First Name		M.I.	Daytime phone ( )
Address				Evening phone ( )
City	State	Zip		Best Time To Call
Date of Birth / /	Age	Social Security Number		Single Divorced Married Widowed
E-Mail Address:				
Occupation (Current or Retired)				Sex Female Male
Race Asian Native Am. African Am. Caucasian Hispanic Other				Height / Weight

In case of Emergency, Contact:

Name	**Relationship**	**Telephone ( )**

Physician Information

Primary Care Physician			Telephone ( )
Address	City	State	Zip

How were you referred here? (Please be specific)

Newspaper _____ Friend or Relative _____
Radio _____ Employee of our Clinic_____
Television_____ Brochure or flyer _____
News story or media announcement_____ Newsletter _____
Physician _____ Other _____

What Research Study Would Most Interest You?

Asthma Psoriasis
Allergy Urticaria (Hives)
COPD Other

Thank you for your interest in our clinical research programs. Kindly confirm that your information can be added to our database to recruit for future trials. Yes No Patient/Guardian Initial and Date _____

Authorization

I hereby authorize the release of requested medical information to the physicians at Sneeze, Wheeze, & Itch Assoc. for Clinical Research. At my request, physicians at Sneeze, Wheeze, & Itch Assoc. may also provide medical information to my physicians.

Signature:_____ Date:_____

Guardian:_____ Date:_____
(if under 18 years of age or required)