Comparison of Age-related Macular Degeneration Treatments Trials

# Baseline Medical History

ID. No.: __ __ - __ __ __ Alpha Code: __ __ __ __

Clinic #: __ __ Week: 000

## INSTRUCTIONS FOR PART A:

Record all previous medical history for the conditions listed in Part A that existed prior to the study enrollment. Read aloud each condition to the patient.

**PART A**

**"I am going to go through some medical conditions and ask you about whether you have ever been diagnosed with that condition.**

**Have you EVER been told by a doctor or other health professional that you have any of the following conditions?"**

| CARDIOVASCULAR/ NEUROLOGICAL CONDITIONS | No | Yes | If yes, number of times condition occurred |
|---|---|---|---|
| 1. MI (heart attack) | ❑0 | ❑1 | |
| 2. Congestive Heart Failure | ❑0 | ❑1 | |
| 3. Stroke | ❑0 | ❑1 | |
| 4. TIA (Transient Ischemic Attack) | ❑0 | ❑1 | |

| CANCERS | A. No Hx | B. Past Hx | C. On-going |
|---|---|---|---|
| 5. Breast | ❑1 | ❑2 | ❑3 |
| 6. Colorectal | ❑1 | ❑2 | ❑3 |
| 7. Prostate | ❑1 | ❑2 | ❑3 |
| 8. Lung | ❑1 | ❑2 | ❑3 |
| 9. Other Cancer: (Specify) _____ | ❑1 | ❑2 | ❑3 |

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**INSTRUCTIONS FOR PART B:**
Record all previous ocular history for the conditions listed in Part B that existed prior to the study enrollment. Read aloud each condition to the patient.

"**Have you EVER been told by a doctor or other health professional that you have any of the following OCULAR conditions?"**

| | Right Eye | | Left Eye | |
|---|---|---|---|---|
| | **No** | **Yes** | **No** | **Yes** |
| 10. Glaucoma | ❑0 | ❑1 | ❑0 | ❑1 |
| 11. Diabetic Retinopathy/ Diabetic Macular Edema | ❑0 | ❑1 | ❑0 | ❑1 |

| | Right Eye | | | Left Eye | | |
|---|---|---|---|---|---|---|
| | **A. No Hx** | **B. Pseudophakic /Aphakic** | **C. On-going** | **A. No Hx** | **B. Pseudophakic /Aphakic** | **C. On-going** |
| 12. Cataracts | ❑1 | ❑2 | ❑3 | ❑1 | ❑2 | ❑3 |

| | Right Eye | | | Left Eye | | |
|---|---|---|---|---|---|---|
| | **A. No Hx** | **B. Past History** | **C. On-going** | **A. No Hx** | **B. Past History** | **C. On-going** |
| 13. Retinal Tear/Detachment | ❑1 | ❑2 | ❑3 | ❑1 | ❑2 | ❑3 |
| 14. Other | ❑1 | ❑2 | ❑3 | ❑1 | ❑2 | ❑3 |
| | a. Specify, Right Eye: _____ | | | b. Specify, Left Eye: _____ | | |

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**INSTRUCTIONS FOR PART C:** Document all other medical history **within 2 years prior** to study enrollment. Medical history refers to all surgeries, allergies, recurring conditions/diseases and/or conditions/diseases requiring ongoing medication or follow-up not listed in Part A. Read aloud each condition to the patient.

## PART C

**"I am going to ask you a series of questions about your medical history in the past two years. I am going to go through various body systems and ask you about some problems related to that area.**

**Within the past two years, have you been told by a doctor or other health professional that you have any of the following problems?"**

| SYSTEM | DIAGNOSIS | HISTORY | | |
|---|---|---|---|---|
| | | A. No Hx | B. Past Hx | C. On-going |
| 15. SKIN | a. Dryness | ❑1 | ❑2 | ❑3 |
| | b. Pruritus (itchiness) | ❑1 | ❑2 | ❑3 |
| | c. Lesions | ❑1 | ❑2 | ❑3 |
| | d. Rashes | ❑1 | ❑2 | ❑3 |
| | e. Basal Cell Carcinoma | ❑1 | ❑2 | ❑3 |
| | f. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 16. EARS/NOSE/ THROAT | a. Hard of hearing | ❑1 | ❑2 | ❑3 |
| | b. Ringing in Ears | ❑1 | ❑2 | ❑3 |
| | c. Allergies/Congestion | ❑1 | ❑2 | ❑3 |
| | d. Difficulty Swallowing | ❑1 | ❑2 | ❑3 |
| | e. Hoarseness/Sore Throat | ❑1 | ❑2 | ❑3 |
| | f. Sinus Pain | ❑1 | ❑2 | ❑3 |
| | g. Nasal Obstruction | ❑1 | ❑2 | ❑3 |
| | h. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 17. RESPIRATORY | a. Pneumonia | ❑1 | ❑2 | ❑3 |
| | b. Asthma | ❑1 | ❑2 | ❑3 |
| | c. Cough/Wheeze | ❑1 | ❑2 | ❑3 |
| | d. Tuberculosis or coughing blood | ❑1 | ❑2 | ❑3 |
| | e. Emphysema | ❑1 | ❑2 | ❑3 |
| | f. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 18. CARDIOVASCULAR | a. Palpitations | ❑1 | ❑2 | ❑3 |
| | b. Angina/Chest Pain/Discomfort | ❑1 | ❑2 | ❑3 |
| | c. Shortness of Breath | ❑1 | ❑2 | ❑3 |
| | d. Arrhythmia/Irregular Heart Beat | ❑1 | ❑2 | ❑3 |
| | e. Hypertension (high blood pressure) | ❑1 | ❑2 | ❑3 |
| | f. Heart Murmur | ❑1 | ❑2 | ❑3 |
| | g. Problem with poor circulation to feet/legs | ❑1 | ❑2 | ❑3 |
| | h. Other (specify) _____ | ❑1 | ❑2 | ❑3 |

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| SYSTEM | DIAGNOSIS | HISTORY | | |
|---|---|---|---|---|
| | | A. No Hx | B. Past Hx | C. On-going |
| 19. GASTROINTESTINAL | a. Acid Reflux | ❑1 | ❑2 | ❑3 |
| | b. Ulcer | ❑1 | ❑2 | ❑3 |
| | c. Irritable Bowel | ❑1 | ❑2 | ❑3 |
| | d. Diverticulitis | ❑1 | ❑2 | ❑3 |
| | e. Crohn's Disease | ❑1 | ❑2 | ❑3 |
| | f. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 20. GENITOURINARY | a. Kidney stones | ❑1 | ❑2 | ❑3 |
| | b. Kidney disease | ❑1 | ❑2 | ❑3 |
| | c. Hernia | ❑1 | ❑2 | ❑3 |
| | d. Nocturia (frequent urination at night) | ❑1 | ❑2 | ❑3 |
| | e. Urinary Tract Infection | ❑1 | ❑2 | ❑3 |
| | f. Prostatitis/BPH (enlarged prostate) | ❑1 | ❑2 | ❑3 |
| | g. Hysterectomy | ❑1 | ❑2 | ❑3 |
| | h. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 21. NEUROLOGICAL | a. Memory loss | ❑1 | ❑2 | ❑3 |
| | b. Headache | ❑1 | ❑2 | ❑3 |
| | c. Sensory/motor disturbance | ❑1 | ❑2 | ❑3 |
| | d. Sleep disturbance | ❑1 | ❑2 | ❑3 |
| | e. Fainting | ❑1 | ❑2 | ❑3 |
| | f. Seizures | ❑1 | ❑2 | ❑3 |
| | g. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 22. MUSCULOSKELETAL | a. Fractures/Dislocations | ❑1 | ❑2 | ❑3 |
| | b. Osteoarthritis | ❑1 | ❑2 | ❑3 |
| | c. Gout | ❑1 | ❑2 | ❑3 |
| | d. Muscle/Joint pain | ❑1 | ❑2 | ❑3 |
| | e. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 23. ENDOCRINE | a. Thyroid dysfunction | ❑1 | ❑2 | ❑3 |
| | b. Diabetes | ❑1 | ❑2 | ❑3 |
| | c. Rheumatoid arthritis | ❑1 | ❑2 | ❑3 |
| | d. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 24. PERIPHERAL VASCULAR | a. Edema (swelling caused by fluid) | ❑1 | ❑2 | ❑3 |
| | b. Phlebitis (blood clots) | ❑1 | ❑2 | ❑3 |
| | c. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 25. HEMATOLOGIC | a. Anemia (low level of iron) | ❑1 | ❑2 | ❑3 |
| | b. Thrombocytopenia (low platelet count) | ❑1 | ❑2 | ❑3 |
| | c. High platelet count | ❑1 | ❑2 | ❑3 |
| | d. Other (specify) _____ | ❑1 | ❑2 | ❑3 |
| 26. METABOLIC | a. Hypercholesterolemia (high cholesterol) | ❑1 | ❑2 | ❑3 |
| | b. Hypertriglyceridemia (excess fatty acids in the blood) | ❑1 | ❑2 | ❑3 |
| | c. Other: (specify) _____ | ❑1 | ❑2 | ❑3 |

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| SYSTEM | DIAGNOSIS | HISTORY | | |
|---|---|---|---|---|
| | | A. No Hx | B. Past Hx | C. On-going |
| 27. ALLERGIES | a. Iodine/shell fish<br>b. Environmental<br>c. Other: (Specify) _____ | ❑1<br>❑1<br>❑1 | ❑2<br>❑2<br>❑2 | ❑3<br>❑3<br>❑3 |
| 28. PSYCHOLOGICAL | a. Depression<br>b. Bipolar<br>c. Other: (Specify) _____ | ❑1<br>❑1<br>❑1 | ❑2<br>❑2<br>❑2 | ❑3<br>❑3<br>❑3 |

29. Initials and certification number of person who completed this form

a. Initials: ___ ___ ___

b. Certification #: ___ ___ ___ ___

30. Date Form Completed

__ __ / __ __ / **2 0** __ __
Month Day Year