Virginia Women's Center
Clinical Trials Interest Questionnaire

Thank you for you for completing the following information. It will be used to determine you suitability for current or future research studies.

Today's Date ___________________ Date of Birth: _____________________

Name: (First)________________________ (MI)____ (Last)____

Address:____

City:____ State:______________ Zip:__________________________________

Have you had an appointment with anyone at Virginia Women's Center in the last 5 years? ____ Yes ____ No

If yes, who?_________________________________

May we contact you about possible research studies? ____ Yes ____ No

Home Phone: ____________________ Work Phone: _______________________ Cell: __________________________

Email address:____

Which is your preferred method of contact: ___ email ___ Home phone ___ Work Phone ___ Cell Phone ___ Mail

Medical Information:

Are you using birth control: ___ Yes ___ No If yes, what type:____

(e.g.: birth control pills, vaginal ring, patch, shot, IUD, tubal ligation, vasectomy, condoms, spermicide, etc.) Please list all.

Have you had a hysterectomy? ___ Yes ___ No If yes, when:____

Have you had your ovaries removed? ___ Yes, 1 ___Yes, 2 ___ No ___ Unknown If yes, when?______________

Have you experienced menopause? ___ Yes ___ No If yes, when was your last period?________________________

Do you have any chronic illnesses? ___ Yes ___ No (e.g.: diabetes, hypertension, thyroid disease, depression, cardiac disease, stomach or bowel problems, etc.)

If yes, please list____

Do you take any medications regularly? ___Yes ___ No If yes, please list below:

____

Do you have any gynecological problems? ___ Yes ___ No (e.g.: uterine fibroids, menstrual cramps, vaginal bleeding, endometriosis, painful (fibrocystic) breasts etc.)

If yes, please list ____

What types of studies would interest you? ***Please check all that apply:***

___*Osteoporosis* ___ *Hormone Replacement Therapy* ___ *Endometriosis*

___ *Uterine Fibroids* ___ *Bladder Problems* ___ *Sexual Dysfunction*

___ *Painful Menstrual Cycles* ___ *Abnormal Pap Smear* ___ *Hot Flashes*

___ *Contraception* ___ *Vaginal Atrophy* ___ *Other:*_________________________

Please print out this completed form, sign it and date it. You may drop it off to any Virginia Women's Center location or return it to us by mail at Clinical Research Department / Virginia Women's Center / 2240 John Rolfe Parkway / Richmond, VA 23233. By signing this form, you are allowing us to contact you in the event we conduct a study of interest to you. Your completion of this form and your signature do NOT obligate you to participate in a study. We appreciate your interest. THANK YOU.

Signature:____ Date:________________________________