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Description automatically generated New Dawn Wellness and Medical Center

12000 Richmond Avenue, Suite 215, Houston, Texas,77082. **Tel:(346)-580-2676, Fax: (917) 900 1647 -**

Pre-Screening Questionnaire for Clinical Research Trials

**Participant Information:**

- Full Name:

- Date of Birth:

- Gender:

- Phone Number:

- Email Address:

- Address:

**Medical History:**

1. Do you have any chronic medical conditions?

- Yes / No

- If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you currently taking any medications (prescription, over-the-counter, or supplements)?

- Yes / No

- If yes, please list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Have you ever been diagnosed with any of the following?

- Heart disease: Yes / No

- Diabetes: Yes / No

- Hypertension (high blood pressure): Yes / No

- Cancer: Yes / No

- Respiratory disorders (e.g., asthma, COPD): Yes / No

- Kidney or liver disease: Yes / No

- Neurological disorders (e.g., epilepsy, multiple sclerosis): Yes / No

- Mental health conditions (e.g., depression, bipolar disorder): Yes / No

- Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you undergone any major surgeries in the past 5 years?

- Yes / No

- If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Do you have any known allergies (e.g., medications, food, environmental)?

- Yes / No

- If yes, please list them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle and Habits:**

6. Do you smoke or use any tobacco products?

- Yes / No

- If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Do you consume alcohol?

- Yes / No

- If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you use any recreational drugs?

- Yes / No

- If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. Are you currently pregnant, planning to become pregnant, or breastfeeding?

- Yes / No / Not Applicable

10. Do you exercise regularly?

- Yes / No

- If yes, please describe your routine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinical Trial Participation:**

11. Have you ever participated in a clinical trial before?

- Yes / No

- If yes, please provide details (study name, date, purpose): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Are you currently enrolled in any other clinical trials?

- Yes / No

- If yes, please provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Are you willing to comply with the requirements of the study, including attending scheduled visits and adhering to study protocols?

- Yes / No

14. Are you willing to undergo the necessary medical tests and procedures required for the study if required?

- Yes / No

15. Do you have any specific concerns or questions about participating in a clinical trial?

- Yes / No

- If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent**:

- I understand that this questionnaire is for pre-screening purposes only and does not guarantee my participation in a clinical trial. I agree to provide accurate information and understand that further screening may be required.

- Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This pre-screening questionnaire will help determine initial eligibility for clinical research trials. Further evaluation and discussion will occur if you meet the preliminary criteria.