BioPharma Services USA Inc.

NEW SUBJECT RECRUITING QUESTIONNAIRE
(MANUAL VERSION)

Last name	
First name	
Gender	Male ☐ Female ☐
Home address including postal code	
E-mail address (optional)	
Valid home phone #	
Other/alternate phone # (optional)	
What is the best time to contact you	Mornings☐ Afternoons☐ Evenings☐
Date of Birth	
Current approximate height	Inches: or Centimeters:
Current approximate weight	Pounds: or Kilograms:
Ethnicity (Hispanic/Latino, Asian, Black, White, Mixed Race)	
Do you smoke or use tobacco products (including occasional smoking)?	☐ Yes ☐ No
If yes, how many times a day/week /month do you smoke or use tobacco products (e.g. cigarettes, cigars, pipes or dips)?	
If no, have you ever smoked or used tobacco products in the past?	☐ Yes ☐ No
If yes, when did you start and date you quit	
Do you have a history of alcohol abuse or dependence (e.g. alcoholism)?	☐ Yes ☐ No
If yes, please specify date of last treatment	
Do you consume any alcohol containing products?	☐ Yes ☐ No
If yes, what type and how many drinks a day/week /month	
Do you have a history of drug abuse or dependence?	☐ Yes ☐ No
Do you use or have you used illicit or street drugs and/or any other drug of abuse (e.g. marijuana, cocaine, hash)?	☐ Yes ☐ No
If yes, please provide the name of the illicit drug(s) and date of last use	
Are you taking any over the counter medication (e.g. Aspirin, vitamins, herbal/natural supplements, Tylenol)?	☐ Yes ☐ No
If yes, please provide the name of the medication and date of last use	
Are you taking any prescription medication (e.g. blood pressure medications, cholesterol medications, antibiotics, sleeping pills, antidepressants)?	☐ Yes ☐ No
If yes, please provide the name of the medication and date of last use	

Have you donated blood in the last 56 days?	☐ Yes ☐ No
If yes, please specify the date and the amount of blood	
Are you participating / have you participated in any other clinical trials elsewhere?	☐ Yes ☐ No
If yes, when was the last study completed?	
How often do you participate in clinical trials/studies (per year)?	
Have you been ill in the last 30 days?	☐ Yes ☐ No
Do you have difficulty swallowing pills, capsules or liquid medications?	☐ Yes ☐ No
Are there any foods you will not eat due to personal and/or religious reasons?	☐ Yes ☐ No
If yes, please specify	
Have you ever had any surgeries of any kind (e.g. heart, kidney, liver, bowel, bone fracture repair surgery)	☐ Yes ☐ No
If yes, please specify the type and date of the surgery	
Do you have any allergies (e.g. food, drugs, environmental)?	☐ Yes ☐ No
If yes, please specify including the type of the reaction	
Any presence or history of endocrine problems (e.g. diabetes)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of heart problems (e.g. low or high blood pressure, angina)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of respiratory problem (e.g. asthma, bronchitis, pneumonia, tuberculosis)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of liver problems (e.g. hepatitis B ,C, liver cirrhosis)	☐ Yes ☐ No
Any presence or history of muscle and/or bone problems (e.g. rheumatoid arthritis)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of kidney and/or bladder problems (e.g. kidney stones, urinary tract infection)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of gastrointestinal problems (e.g. ulcer, gastritis, colitis, chronic diarrhea/constipation, hemorrhoids)?	☐ Yes ☐ No

If yes, please specify	

Any presence or history of psychiatric and/or psychological disorders (e.g. depression, anxiety)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of neurological disorders (e.g. migraines, seizures including epilepsy)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of skin problems (e.g. eczema, psoriasis)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of immunological problems (e.g. systemic lupus erythematosus)?	☐ Yes ☐ No
If yes, please specify	
Any presence or history of hematological (blood) disorders (e.g. anemia)?	☐ Yes ☐ No
If yes, please specify	
Do you have any other medical conditions and/or health problems?	☐ Yes ☐ No
If yes, please specify	
Do you agree for us to contact you for future study participation?	☐ Yes ☐ No
FOR FEMALES ONLY	
What is your reproductive status?	Able to have children☐ Post-menopausal☐ Surgically Sterile☐
If able to have children, is your menstrual cycle regular?	☐ Yes ☐ No
If yes, please specify cycle days (e.g. 21, 28, 30)	

Completed by:_____ (initials and date)
Entered into Database by:_____(initials and date)
QC Review:_____ (initials and date)