

Sneeze, Wheeze, & Itch Associates
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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.

Date: _____

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		<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
					<input type="checkbox"/> Married	<input type="checkbox"/> Widowed
E-Mail Address:						
Occupation (Current or Retired)					Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
Race <input type="checkbox"/> Asian <input type="checkbox"/> Native Am. <input type="checkbox"/> African Am. <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> 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)						
<input type="checkbox"/> Newspaper _____	<input type="checkbox"/> Friend or Relative _____					
<input type="checkbox"/> Radio _____	<input type="checkbox"/> Employee of our Clinic _____					
<input type="checkbox"/> Television _____	<input type="checkbox"/> Brochure or flyer _____					
<input type="checkbox"/> News story or media announcement _____	<input type="checkbox"/> Newsletter _____					
<input type="checkbox"/> Physician _____	<input type="checkbox"/> Other _____					

What Research Study Would Most Interest You?						
<input type="checkbox"/> Asthma	<input type="checkbox"/> Psoriasis					
<input type="checkbox"/> Allergy	<input type="checkbox"/> Urticaria (Hives)					
<input type="checkbox"/> COPD	<input type="checkbox"/> 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)						