

**Sneeze, Wheeze, & Itch Associates**  
 Anjuli S. Nayak, MD • Nicholas A. Nayak, MD  
 309-452-0995  
 www.asthma2.com

**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
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
<b>In case of Emergency, Contact:</b>						
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. We want to make your visits here as pleasant as possible. Please let us know if we can be of any assistance to you.

**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)