



Virginia Women's Center: Clinical Trials Interest Questionnaire

Thank you for completing the following information. It will be used to determine your 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 any provider at Virginia Women's Center in the last five years? ___ Yes ___ No

If yes, who? _____ May we contact you about possible research studies? ___ Yes ___ No

Home phone: _____ Work phone: _____ Cell phone: _____

Email address: _____

Which is your preferred method of contact? ___ Home phone ___ Work phone ___ Cell phone ___ Mail ___ Email

Medical Information:

Are you using birth control? (e.g.: birth control pills, vaginal ring, patch, shot, IUD, tubal ligation, vasectomy, condoms, spermicide, etc.)
___ Yes ___ No If yes, please list all types: _____

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? (e.g.: diabetes, hypertension, thyroid disease, depression, cardiac disease, stomach or bowel problems, etc.) ___ Yes ___ No If yes, please list: _____

Do you take any medications regularly? ___ Yes ___ No If yes, please list: _____

Do you have any gynecologic problems? (e.g.: uterine fibroids, menstrual cramps, vaginal bleeding, endometriosis, painful (fibrocystic) breasts, etc.) ___ Yes ___ No If yes, please list: _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hormone Replacement Therapy | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Painful Menstrual Cycles | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Contraception | <input type="checkbox"/> Vaginal Atrophy | <input type="checkbox"/> Other: _____ |

Please print out this completed form, sign it and date it. You may drop it off at 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. Thank you for your interest.

Signature: _____ Date: _____