S17r1 Interim Medical History

Patient's Identification Number _____

Visit Date (yyyy/mm/dd): _____

Correction ☐ Yes ☐ No

Since last contact, has patient had

1. Sudden painless weakness on one side of body? ☐ Yes ☐ No

2. Sudden numbness or a dead feeling on one side of body? ☐ Yes ☐ No

3. Sudden painless loss of vision in one or both eyes? ☐ Yes ☐ No

4. Suddenly lost one-half of vision? ☐ Yes ☐ No

5. Suddenly lost the ability to understand what people were saying? ☐ Yes ☐ No

6. Suddenly lost the ability to express his/herself verbally or in writing? ☐ Yes ☐ No

7. Hospitalization for pain? If Yes, complete Form 34. ☐ Yes ☐ No

8. Hospitalization for priapism? If Yes, complete Form 34. ☐ Yes ☐ No

9. Hospitalization for Acute Chest Syndrome (ACS)? If Yes, complete Form 34. ☐ Yes ☐ No

10. Hospitalization for Asthma? If Yes, complete Form 34. ☐ Yes ☐ No

11. Intensive care unit admission? If Yes, complete Form 34. ☐ Yes ☐ No

12. Adverse event (AE)? If YES, complete Form 25 ☐ Yes ☐ No

13. Serious adverse event (SAE)? If YES, complete Form 24. ☐ Yes ☐ No

14. Headaches? If YES, complete Form 14. ☐ Yes ☐ No

Staff I.D. #: _____