

**ATLANTIC RESEARCH CENTER, LLC**  
**AFFILIATES OF ATLANTIC ALLERGY, ASTHMA, AND IMMUNOLOGY, LLC**

If you think you might be interested in participating in one of our clinical trials and would like more information, please answer the following questions and give this form to the receptionist.

Name: \_\_\_\_\_ Male / Female

Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_ Do you have seasonal allergies? Yes / NO

Do you have asthma? Yes / NO Do you have year round allergies? Yes / NO

Do you suffer from sinus infections more than 3 times a year? Yes / NO Are you receiving allergy shots? Yes / NO

Do you have any medical conditions, such as diabetes or hypertension?

\_\_\_\_\_

\_\_\_\_\_

Please list any medications you are currently taking, including over the counter medications.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please give us a phone number where we can reach you- \_\_\_\_\_