

Surname:	l learnt about the Clinical Pharmacology Unit Antwerp through:
First name:	Newspaper/magazine advertisement
(As stated on your identity card. Please write your name in block capitals.)	☐ Word of mouth
	Referred by this volunteer
DEMOGRAPHIC DETAILS	☐ Website
Sex: male female	☐ Flyer/Poster ☐ Leaflet from GP or Specialist
	Name of doctor
Date of birth: Place of birth:	Number of desical
Ethnic origin: ☐ white ☐ black ☐ indian ☐ asian ☐ other:	GENERAL MEDICAL DETAILS
Nationality:	
Language: NL / FR / EN / other:	Blood group: O A + O B + O AB + O O +
	O A - O B - O AB - O O -
CONTACT DETAILS	Hoight: om
Official address:	Height: cm Weight: kg
Street:	Weight. Ng
House number: Box number:	Women only:
Zip Code: City:	Do you use any form of birth control?
Email address:	□ No
Telephone: _ _ _ _ or mobile phone:	Yes, the pill, please specify:
	Yes, UDD Sterilised hysterectomy (removal of the uterus)
	Are you in the menopause? No yes, since: / /
BANK ACCOUNT NUMBER	Are you on hormone replacement therapy? ☐ No ☐ yes, please specify:
Beneficiary:	
IBAN _	Do you smoke?
BIC _	no, never smoked
(* Please always state your IBAN and SWIFT BIC numbers)	not anymore: I smoked from / / to / /
	about cigarettes/cigars per day
GENERAL PRACTITIONER	☐ yes, since / / about cigarettes/cigars* per day
Name:	Do you drink alcohol?
Street:	□ no
Box number: Zip Code :	☐ yes, units per week (<i>fill in the number of units</i>)
City:	(1 unit = 1 glass of beer/wine/spirits)
Telephone: _ _ _ _	
reichnone.	



Do you take drugs? ☐ no	Cholesterol: ☐ no ☐ yes
yes, please specify Frequency*: daily – weekly – monthly – yearly	Glaucoma: ☐ no ☐ yes If yes: since when:
Do you follow a special diet? ☐ no ☐ yes If yes, what diet? ☐ Halal ☐ Kosher ☐ Vegetarian ☐ Other:	Skin disorder: • eczema:
Are you willing to eat meat during the study: ☐ yes ☐ no MEDICAL DETAILS	Cold sores (Herpes Labialis): ☐ no ☐ yes If yes: since when:
Allergies: ☐ no ☐ yes If yes: please specify:	Other disorders: ☐ no ☐ yes If yes, please specify:
	Operations: ☐ no ☐ yes If yes: please specify what operations and when:
Type 1 diabetes: ☐ no ☐ yes or Type 2 diabetes: ☐ no ☐ yes High blood pressure: ☐ no ☐ yes	
Heart disorder: ☐ no ☐ yes If yes: please specify:	Do you use any medication? ☐ no ☐ if yes, please specify:
Lung disorder: • Asthma: □ no □ yes	
COPD: □ no □ yes Other:	Are you willing to stay overnight at our unit? ☐ no ☐ yes
Migraines: ☐ no ☐ yes If yes: how often:	If you want to participate in trials at the CPU Antwerp, you should submit a copy of your identity card with your registration form or bring it along to your next appointment.
Thyroid disorder: ☐ no ☐ yes	



REGISTRATION FORM

In accordance with the privacy legislation applicable in Belgium (General Data Protection Regulation), your permission is hereby requested to:

- The details of this registration form will be included in the volunteer database of SGS LS, Clinical Pharmacology Unit Antwerp
- Keep a copy of your identity card.

You have the right to inspect and improve the data stored about you. As well as the right to dispose of this information at any time, to change it or have it removed from the volunteer file of SGS LS, Clinical Pharmacology Unit Antwerp.

Signature:	Date: _