Dr A. Jacovides Clinical Trials Participant Application Form

Full Names	
Date of Birth:	
GPs name:	
Contact Details:	
• Mobile	
• Landline	
• Email address	
• Alternate contact numbers:	
Known allergies:	
Do you smoke? ☐ YES ☐ NO	
Have you ever tested positive for COVID-19?	
Have you been vaccinated for COVID-19?	
Have you ever had or currently have any of the following (tick all that apply)?	
☐ Heart attack	☐ Angina
☐ Cardiac Stents	☐ Stroke
☐ High Cholesterol	☐ High blood pressure
☐ Diabetes	☐ Asthma
☐ Heart failure	☐ Kidney failure
☐ Emphysema	☐ Pneumonia
☐ Arthritis	☐ Poor circulation
☐ Other	
Are you interested in potentially participating in a clinical trial?	
☐ YES ☐ NO	
Which area would be of interest to you (please base your answer on what is potentially applicable to you):	

PLEASE COMPLETE AND EMAIL BACK TO trials@midrandmedicalcentre.co.za