RELIANCE CLINICAL TESTING SERVICES, INC.
3207 ESTERS ROAD
IRVING, TX. 75062
TEL: 972-871-7578
FAX: 972-871-7579

PANELIST INFORMATION SHEET

Your responses to the attached questions will be used to determine your eligiblility to participate on clinical studies. The information you provide will be kept confidential according to federal privacy regulations. If at any time you no longer wish to be considered for clinical studies you can write RCTS at the above address and request that your information be made inactive.

Panelist Number | IRV **(Leave This Box Blank)**

E Mail Address

Legal First Name | Legal Last Name | Middle Initial

Address | Apartment #

City | State | Zip

Home Telephone # | Work Telephone # | Age | Date of Birth (Month/Day/Year)

Occupation | Employer

Gender

- ○ Male
- ○ Female

Marital Status

- ○ Single
- ○ Married
- ○ Divorced
- ○ Separated
- ○ Widowed

Ethnicity

- ○ African American
- ○ Caucasian
- ○ Hispanic
- ○ Native American
- ○ Asian/Pacific Islander (describe) _____
- ○ Other _____

Please provide the following information for all minor children (under 18 yrs. old) in your household:

Name	Date of Birth		Sex
			○ Male ○ Female
			○ Male ○ Female
			○ Male ○ Female
			○ Male ○ Female

Did anyone refer you to us? If so, print their FULL name in the box below.

_____ _____

If you were not referred by someone, how did you hear about us?

- ○ RCTS Website
- ○ Walk-In
- ○ Greensheet
- ○ Dallas Observer
- ○ Facebook
- ○ Craigslist
- ○ Irving Rambler News
- ○ Dallas Morning News
- ○ Irving Parent Magazine
- ○ Other Testing Facility (specify) _____
- ○ Radio Ad (list station) _____
- ○ Internet Search (search engine) _____
- ○ Flyer at School (specify) _____
- ○ Flyer at Apartment (specify) _____
- ○ Flyer Other Location (specify) _____
- ○ La Leche League
- ○ Birth Network
- ○ Social Group (specify) _____
- ○ Other (describe) _____

What is your primary mode of transportation?

- ○ DART Bus
- ○ Personal Vehicle
- ○ Walk/Bike
- ○ Other (specify)
- ○ Prefer not to answer

Please check the appropriate box under each category:

Self Perceived Skin Type

- ☐ Dry
- ☐ Normal
- ☐ Oily
- ☐ Dry/Normal Combination
- ☐ Normal/Oily Combination
- ☐ Dry/Oily Combination

Fitzpatrick Scale

- ☐ Skin Type I: Always burns easily, never tans (sensitive)
- ☐ Skin Type II: Always burns easily, tans minimally (sensitive)
- ☐ Skin Type III: Burns moderately, tans gradually (light brown/normal)
- ☐ Skin Type IV: Burns minimally, always tans well (moderate brown/normal)
- ☐ Skin Type V: Rarely burns, tans profusely (dark brown/insensitive)
- ☐ Skin Type VI: Never burns, deeply pigmented (insensitive)

Does Your Skin Get Dry In The Winter? ○ Yes ○ No

Does Your Skin Itch When You Wear Clothes Containing Wool? ○ Yes ○ No

Have you ever used Ivory Soap? ○ Yes ○ No

Do you experience any of the following when using Ivory soap?

☐ The feeling of dryness ☐ Itching ☐ Burning
☐ The feeling of roughness ☐ Redness ☐ None of the above

Do you use a Depilatory? ○ Yes ○ No

If yes, please indicate which kind.... ☐ Neet ☐ Nair ☐ Wax ☐ Other (list below)

_____

Nails ☐ Natural ☐ Wraps ☐ Tips ☐ Sculptured ☐ Gels ☐ Press On

Hair Type ☐ Dry ☐ Normal ☐ Oily

Hair ☐ Colored ☐ Relaxed ☐ Permed ☐ Natural

Do You Have Dandruff? ○ Yes ○ No

Do You Wear Contact Lenses? ○ Yes ○ No

If so, please specify... ☐ Soft Daily Wear ☐ Soft Extended Wear ☐ Gas Permeable ☐ Hard

Do you use any of the following products? Check all that apply:

Facial Cleanser

- ☐ Cream
- ☐ Liquid
- ☐ Gel
- ☐ Facial Soap Bar
- ☐ Bath Soap
- ☐ Facial Wipes
- ☐ None

Toner

- ☐ Alcohol
- ☐ Non-Alcohol
- ☐ Medicated
- ☐ None

Mask

- ☐ Wash Off
- ☐ Peel Off
- ☐ Scrub
- ☐ None

Moisturizer

- ☐ Lotion
- ☐ Cream
- ☐ Gel
- ☐ None

Foundations

- ☐ Powder
- ☐ Cream
- ☐ Liquid
- ☐ None

Nail and Hand Care

- ☐ Nail Color
- ☐ Hand Creams
- ☐ Cuticle Creams
- ☐ None

Specialty Products

- ☐ Eye Treatments (Creams, Lotions, etc...)
- ☐ Alpha Hydroxy Acids (Lactic Acid, Glycolic Acid, etc...)
- ☐ Acne/Pimple (Benzoyl Peroxide)
- ☐ Other

Lip Products (Lipstick, Liner, etc...) ○ Yes ○ No

Eye Products (Shadow, Liner, etc...) ○ Yes ○ No

Are you selective about the cosmetic, personal care products, and laundry products you use?

☐ Yes ☐ No

If Yes, why are you selective about the cosmetic, personal care products, and laundry products you use? (Check all that apply)

☐ Price
☐ Brand Loyalty
☐ Tingling occurs to brands other than my usual brands
☐ Itchiness occurs to brands other than my usual brands
☐ Burning occurs to brands other than my usual brands
☐ Stinging occurs to brands other than my usual brands
☐ Other, explain below

If tingling, itchiness, burning, or stinging occurs after using brands other than your ususal brands, please answer the following:

Duration of Sensation

○ Sensation subsides within minutes or hours after discontinuing use of product
○ Sensation subsides within 2 days of discontinuing use of product
○ Sensation persists for 3 days or more

Other reasons for being selective about use of cosmetic, personal care products, and laundry products:

Please Complete the following Medical History and Allergy Sections. If none of the listed conditions or allergies apply, please check the box marked "None" at the end of each section.

MEDICAL HISTORY

Have you ever been diagnosed by a physician for any of the following medical conditions?
Check all that apply:

	Year Diagnosed?	Medication(s) Taking?	Dosage(s)?	Permanent or Temporary?
□ Diabetes				
□ Heart Problems				
□ High Blood Pressure				
□ Kidney Problems				
□ Acne/Pimples				
□ Dermatitis				
□ Eczema				
□ Psoriasis				
□ Hayfever				
□ Asthma				
□ Cancer				
□ HIV Positive				
□ Ulcers				
□ Thyroid Disease				
□ Hemorrhoids				
□ Arthritis				
□ Athlete's Foot				
□ Hormone Replacement				
□ Neurological Problems				
□ Gastrointestinal Problems				
□ Ear/Nose/Throat Problems				
□ Liver Disease				
□ Hepatitis				
□ Lung Disease				
□ Sexually Transmitted Disease				
□ Allergies				
□ Atopic Dermatitis				
□ Canker Sores				
□ Rosacea				
□ Lupus				
□ Other (Describe)				
□ NONE				

Are you allergic to any of the following? Check all that apply: If none apply, please check "None."

☐ Fragrances	☐ Antiperspirants	☐ Preservatives	☐ Other (Describe)
☐ Soaps	☐ Deodorants	☐ Adhesives (Band Aids)	☐ None
☐ Cosmetics	☐ Foods	☐ Suntanning Products	
☐ Detergents	☐ Medicines	☐ Bath Products (oils, herbals, etc...)	

If you checked any of the above, please explain any allergies in detail: (i.e. How long have you been allergic? (List the year allergy was noticed.) Is your allergy specific to certain brands of products? Is there redness, dryness, sneezing etc. associated with your allergy?)

The following questions pertain to women only:

What method of birth control do you practice? Check all that apply:

☐ Abstinence	☐ Birth Control Pills	☐ Foams	☐ Tubal Ligation	☐ None
☐ Condoms	☐ Birth Control Patch	☐ Diaphragm	☐ Sponge	
☐ IUD	☐ Implants/Injections	☐ Nuva Ring	☐ Vasectomy (Partner)	

Are you pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Have you had a hysterectomy? ○ Yes ○ No

Do you menstruate regularly? ○ Yes ○ No

Have you been post-menopausal for at least one-year? ○ Yes ○ No

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To the best of my knowledge, the above information is true and I consider myself to be in general good health.

Signature _____

Date _____

Other contact information:

Name of contact _____ Relationship to contact _____

Phone Number (other than above) _____