Draft

INTAKE FORM: Page 1

Please answer all questions on this page.
PRINT carefully and use black ink.
When you are done, return this page to the pharmacist.

Place label from requisition form here

1. Today's date: ___ (Month) - ___ (Day) - 2 0 0 ___ (Year)

2. What are your initials? ___ (First) - ___ (Middle) - ___ (Last)

3. Date of birth: ___ (Month) - ___ (Day) - 1 9 ___ (Year)

4. Race or ethnic group (please fill in one circle):
○ Black ○ White
○ Hispanic ○ Asian
○ Other _____

5. Gender: ○ Male ○ Female

6. How many days ago did you first feel your cold sore/fever blister? ___ Days ago

7. How many cold sore episodes have you had in the past 12 months? ___ Episodes

8. How old were you when you had your first cold sore/fever blister? ___ Years old

9. How long do your cold sore/fever blister episodes last, on average? ___ Days

Compensation

In order to compensate you for participating in this study, we need your name and address. Please PRINT clearly and provide all of the information requested.

Name: _____ (First Name) _____ (Last Name)

Street Address: _____

City: _____ **State:** ___ **Zip:** _____

FAX TO PIVOTAL DATA - (303) 778-0378

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INTAKE FORM: Page 2

You may find some information requested on this page to be of a personal nature, which you may not want to share with the pharmacist. When you have answered all questions, please place this page in the envelope, seal it and return it to the pharmacist. The pharmacist will mail the envelope, unopened, to Pivotal Data.

1. Have you ever been diagnosed with either of the following:

○ Yes ○ No Cancer?

○ Yes ○ No HIV/AIDS?

2. In the past twelve months, have you received:

○ Yes ○ No Treatment for cancer?

○ Yes ○ No An organ or bone marrow transplant?

3. Have you ever used any of the following medications?

○ Yes ○ No Famvir (Famciclovir)

○ Yes ○ No Denavir (Penciclovir)

○ Yes ○ No Zovirax (Acyclovir)

○ Yes ○ No Valtrex (Valacyclovir)

4. Are you currently using any of the following medications?

○ Yes ○ No Famvir (Famciclovir)

○ Yes ○ No Zovirax (Acyclovir)

○ Yes ○ No Valtrex (Valacyclovir)

5. Please fill in the circle to the left of each drug you have used. If you have not used any of these drugs, please fill in the circle to the left of "I have not used any of these medicines".

○ AZT	○ Combovir	○ Crixivan	○ Cytovene
○ Epivir	○ Foscavir	○ HIVID	○ Imuran
○ Invirase	○ Kytril	○ Leukovorin	○ Navelbine
○ Norvir	○ Proscar	○ Resciptor	○ Retrovir
○ Rivid	○ Taxotere	○ Taxol	○ Videx
○ Viracept	○ Viramune	○ Zerit	○ Zofran
○ d4t			

○ I have not used any of these medicines.