**Johns Hopkins Hospital—Food and Drug Administration Thromboembolism Pilot Study**
**(Cooperating Hospital Thromboembolism and Controls Study)**

Name _____ (Last) (First) (Middle) S M SEP W D (Marital status—circle)

Maiden name _____ (Last) (First) Age last birthday _____ (On admission)

Race _____ (W, NW) Birthdate _____ (Month, Day, Year) Birthplace _____ (City/County) (State/Country)

*Address on admission _____ (Street) Telephone _____

_____ (City/County) _____ (State/Country)

Next of kin or responsible friend _____ (Last) (First name) (M. I.) Relationship or friend _____ (Specify)

Address _____ (Street) _____ (City/County) _____ (State/Country)

Name of spouse _____ Employer _____ Business telephone _____

Business address _____ (Street) _____ (City/County) _____ (State/Country)

Patient employed: No ____ Yes _____ (Employer) Social security No. _____

Business address _____ Business telephone _____

Hospital _____ (Name) (Code number) Hospital record No. _____

Dates: Adm. _____ Disch. _____ Blue Cross: No ____ Yes _____ (Specify number)

Admission service _____ If transferred to other service _____ (Specify)

Attending physician _____ Telephone _____

Address _____ (Street) _____ (City/County) _____ (State/Country)

At last observation: Living _____ Dead _____ (If dead, complete other side)

Reviewer _____ Date form completed _____

*If moved, enter new address below:

Last known address _____ (Street) Date _____ (Month, Day, Year)

_____ (City/County) _____ (State/Country)

Hospital code No. _____ Patient series No. _____