University of Washington Medical Center
University Reproductive Care

ENDOCRINE NEW PATIENT HISTORY

Please complete this form and bring it with you to your scheduled appointment.

_____

CONTACT INFORMATION:

First name: _____Middle initial: _____

Last name:_____

Preferred name:_____ Self-declared gender:_____

Preferred pronouns (he/him, she/her, etc.) _____

Birth date:_____Age:____Occupation:_____

Home Street Address_____

City: _____State____Zip Code: _____

Indicate which number to call or leave a message:

Home Phone: (____) _____ Cell Phone: (____) _____

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Other _____

Spouse/Partner: ☐ Not Applicable

First Name: _____Last Name_____

Birth date:_____ Age: _____Occupation _____

Who referred you?

☐ Physician

Name: _____Clinic: _____

Phone: (___)_____Address: _____

☐ Former Patient/Friend: _____

☐ Website/Advertisement: _____

☐ Insurance Carrier: _____

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian/ White
☐ Eastern European
☐ Hispanic/Caribbean
☐ Northern European
☐ Southern European
☐ Other: _____

Would you like to be screened for?

Cystic Fibrosis	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Tay - Sachs disease	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No

☐ Other_____

PLACE PATIENT LABEL HERE

Who is your Ob/Gyn?

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

MEDICAL HISTORY AND INFORMATION:

Primary reason for visit:_____
_____

What is your primary goal for this visit?_____
_____

Menstrual History:
Age when you had your first period: _____
Age when you first noticed breast development: _____ pubic hair: _____underarm hair: _____
Age of menopause_____ Did you use hormone replacement? □ No □ Yes

Current menstrual cycle pattern: □ Regular □ Irregular (if irregular check all that apply)
□ <25 days □ >35 days □ No periods □ Heavy □ Light □ Bleed between periods □ Bleed after sex

Number of days between the start of one period to the start of the next period: _____
How many periods do you have a year? _____ How many days of bleeding do you have?_____
Dates of the 1st day of your last 2 periods (month/day/year): ____/____/____ , ____/____/____
If you do not have periods, at what age did you stop having them? _____
Do you have severe menstrual cramps/pain? □ No □ Yes: Always __Sometimes __ In the Past___

Contraceptive History: (please check all that apply and provide dates of use) □ N/A □ None
□ Condoms _____ □ Diaphragm_____ □ IUD_____
□ Implanon/Nexplanon_____ □ Birth control pills_____
□ Patch _____ □ Nuva-ring _____
□ Injectable (Depo-Provera, Lunelle etc.) _____
□ Tubal sterilization (tubes tied, cut, burned, Essure, etc.) date ____/____/____ Type:_____

Sexual History: Are you currently sexually active? □ No □ Yes
Is your partner(s) □ Male □ Female □ Transgendered
Do you have pain with intercourse? □ **No** □ Yes
Do you desire pregnancy now? □ **No** □ Yes

Have you been treated for or diagnosed with one of the following sexually transmitted infections?
□ **No** □ Yes (Please check all that apply and provide the date of diagnosis)
□ Chlamydia _____ □ Gonorrhea _____ □ Herpes _____ □ Hepatitis B _____
□ Genital warts (HPV) _____ □ Syphilis _____ □ HIV/AIDS _____

Have you been treated for or diagnosed with one of the following problems?
□ **No** □ Yes (Please check all that apply and provide the date of diagnosis)
□ Ovarian failure_____ □ Ovarian cysts (specify type)_____ □ Fibroids_____
□ Endometriosis_____ □ Tubal disease_____ □ Uterine polyps_____
□ Pelvic inflammatory disease (PID)_____ □ Thyroid disease_____ □ Osteoporosis_____
□ Hyperprolactinemia_____ □ Adrenal disease_____ □ Eating disorder_____

Pap Smear History:
When was your last pap smear (month and year)? ____/____
Have you ever had an abnormal pap smear □ **No** □ Yes
If yes, when was your last abnormal pap smear?____/____
Have you had any of the following treatments for abnormal pap smear? (please check all that apply)
□ Colposcopy □ Cryosurgery (freezing) □ Laser treatment □ Conization □ LEEP procedure

Breast Screening History:
Do you perform breast self-exams? □ No □ Yes
Have you ever had a mammogram? □ No □ Yes – date ___/___/___ Result: □ Normal □ Abnormal – explain _____

Pregnancy Summary:
Total number of ALL pregnancies: _____
How many living children do you have? _____
Miscarriages (less than 20 weeks): _____ Ectopic/Tubal Pregnancies: _____
Elective Terminations (abortions): _____ Full Term Deliveries (more than 37 weeks): _____
Premature Deliveries (less than 37 weeks): _____
Do you have any children with birth defects? □ **No** □ Yes _____

Did you have any complications with pregnancy?
□ **No** □ Yes (please check all that apply):
□ infection □ heavy bleeding/hemorrhage □ could not make breast milk
□ diabetes □ high blood pressure □ retained placenta □ D&C after delivery
□ other_____

Medical History:
Are you allergic to any medications or foods? □ **No** □ Yes (list allergies and describe reactions)

Drug or food	Reaction

List all medications, including over-the-counter medicines, herbal remedies, and vitamins

Medication	Dose	Why are you taking this medication

Do you have any medical problem(s)? ☐ **No** ☐ Yes (please list type, dates and treatments)

Medical problem	Diagnosis date	Treatments

Social History:

Number of caffeinated beverages (coffee, tea, soda) per day? _____

Do you smoke cigarettes? ☐ **No** ☐ Quit/when___ ☐ Yes Number of years___ Cigarettes/day_____

Do you drink alcohol? ☐ **No** ☐ Yes

Number of drinks per week: Beer ____ Wine ____ Liquor _____

Do you use recreational drugs (i.e. marijuana)? ☐ **No** ☐ Yes (describe) _____

_____

Do you Exercise? ☐ No ☐ **Yes** -- Number of hours per week _____

Type_____

Do you feel safe at home? ☐ **Yes** ☐ No

Surgical History:

Have you had any surgeries? ☐ **No** ☐ Yes (please list)

Did you have any anesthesia problems? ☐ **No** ☐ Yes (describe):_____

Year	Reason and Type of Surgery
1.	
2.	
3.	
4.	

Review of Physical Symptoms:

General
- ☐ Fever/chills
- ☐ Recent weight gain or loss
- ☐ Anorexia/bulimia
- ☐ Lack of energy
- ☐ Other:_____
- ☐ **None**

Head, Eyes, Ears, Nose and Throat
- ☐ Hearing loss/deafness
- ☐ Loss of sense of smell
- ☐ Chronic nasal congestion
- ☐ Blurred vision ☐ Ringing ears
- ☐ Other:_____
- ☐ **None**

Respiratory
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia ☐Tuberculosis
- ☐ CPAP machine
- ☐ Other_____
- ☐ **None**

Endocrine/Hormonal
- ☐ Thyroid gland problems
- ☐ Diabetes
- ☐ Frequently hot or cold
- ☐ Rapid weight gain/loss
- ☐ Hot flashes
- ☐ Increased hunger/thirst
- ☐ Adrenal disorder
- ☐ Other_____
- ☐ **None**

Breasts
- ☐ Surgery (Type:_____)
- ☐ Discharge (Type:_____)
- ☐ Lumps
- ☐ Pain
- ☐ Cancer
- ☐ Other_____
- ☐ **None**

Neurological
- ☐ Dizziness
- ☐ Weakness or loss of balance
- ☐ Seizures/Epilepsy
- ☐ Stress headaches
- ☐ Migraine headaches
- ☐ Numbness
- ☐ Memory Loss
- ☐ Other_____
- ☐ **None**

Mental Health
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar depression disorder
- ☐ Personality disorder
- ☐ Eating disorder
- ☐ Suicidal
- ☐ Other_____
- ☐ **None**

Kidney/Urinary
- ☐ Kidney cysts
- ☐ Frequent bladder infections
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Other_____
- ☐ **None**

Skin/extremities
- ☐ Acne
- ☐ Excessive facial or body hair
- ☐ Cancer
- ☐ Hair loss
- ☐ Eczema
- ☐ Rash
- ☐ Other_____
- ☐ **None**

Cardiovascular
- ☐ Murmurs
- ☐ Chest pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Mitral valve prolapse (antibiotics are required with dental procedures ☐ No ☐Yes)
- ☐ Other:_____
- ☐ **None**

Hematologic
- ☐ Blood clots
- ☐ Sickle cell anemia
- ☐ Easy bruising
- ☐ Swollen glands/lymph nodes
- ☐ Stroke
- ☐ Blood Transfusion date and reason:_____
- ☐ Other_____
- ☐ **None**

Gastrointestinal
- ☐ Ulcers
- ☐ Nausea/Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Blood in stool
- ☐ Irritable bowel disease
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ Other:_____
- ☐ **None**

Musculoskeletal/Immune
- ☐ Osteoporosis
- ☐ Decreased energy/fatigue
- ☐ Rheumatoid arthritis
- ☐ Lupus erythematosus
- ☐ Myasthenia gravis
- ☐ Other_____
- ☐ **None**

Family History	**Living**	**Age and Cause of Death**
Mother	☐ Yes – age: ☐ No	
Father	☐ Yes – age: ☐ No	
Brothers (number=___)	☐ Yes – ages: ☐ No	
Sisters (number=____)	☐ Yes – ages: ☐ No	
Maternal Grandmother	☐ Yes – age: ☐ No	
Maternal Grandfather	☐ Yes – age: ☐ No	
Paternal Grandmother	☐ Yes – age: ☐ No	
Paternal Grandfather	☐ Yes – age: ☐ No	

Disorders in Your Family

		Relationship to you		
Breast Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Ovarian Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Colon Cancer	☐ Yes	_____	☐ No	☐ Don't Know
Other Cancer_____	☐ Yes	_____	☐ No	☐ Don't Know
Diabetes	☐ Yes	_____	☐ No	☐ Don't Know
Thyroid Problems	☐ Yes	_____	☐ No	☐ Don't Know
Heart Disease	☐ Yes	_____	☐ No	☐ Don't Know
Blood Clots	☐ Yes	_____	☐ No	☐ Don't Know
Psychiatric Problems	☐ Yes	_____	☐ No	☐ Don't Know
Tuberculosis	☐ Yes	_____	☐ No	☐ Don't Know
Endometriosis	☐ Yes	_____	☐ No	☐ Don't Know
Menopause before age 40	☐ Yes	_____	☐ No	☐ Don't Know
Birth Defects	☐ Yes	_____	☐ No	☐ Don't Know
Cystic Fibrosis	☐ Yes	_____	☐ No	☐ Don't Know
Tay-Sachs Disease	☐ Yes	_____	☐ No	☐ Don't Know
Canavan Disease	☐ Yes	_____	☐ No	☐ Don't Know
Bloom Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Gaucher Disease	☐ Yes	_____	☐ No	☐ Don't Know
Niemann-Pick Disease	☐ Yes	_____	☐ No	☐ Don't Know
Fanconi Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Familial Dysautonia	☐ Yes	_____	☐ No	☐ Don't Know

Muscular Dystrophy	☐ Yes	_____	☐ No	☐ Don't Know
Neurologic (brain/spine)	☐ Yes	_____	☐ No	☐ Don't Know
Neural Tube Defects	☐ Yes	_____	☐ No	☐ Don't Know
Bone/Skeletal Defects	☐ Yes	_____	☐ No	☐ Don't Know
Dwarfism	☐ Yes	_____	☐ No	☐ Don't Know
Developmental Delays	☐ Yes	_____	☐ No	☐ Don't Know
Learning Problems	☐ Yes	_____	☐ No	☐ Don't Know
Polycystic Kidneys	☐ Yes	_____	☐ No	☐ Don't Know
Heart defect from birth	☐ Yes	_____	☐ No	☐ Don't Know
Down Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Other Chromosome defects	☐ Yes	_____	☐ No	☐ Don't Know
Marfan Syndrome	☐ Yes	_____	☐ No	☐ Don't Know
Hemophilia	☐ Yes	_____	☐ No	☐ Don't Know
Sickle Cell Anemia	☐ Yes	_____	☐ No	☐ Don't Know
Thalassemia	☐ Yes	_____	☐ No	☐ Don't Know
Galactosemia	☐ Yes	_____	☐ No	☐ Don't Know
Deafness/Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Color Blindness	☐ Yes	_____	☐ No	☐ Don't Know
Hemochromatosis	☐ Yes	_____	☐ No	☐ Don't Know
	☐ Other-Specify _____			

Emotional Status: Please rate on a scale of 1-10 (1 is best and 10 is worst)

How do you estimate your average level of stress to be? 1 2 3 4 5 6 7 8 9 10
Over the last two weeks have you felt little pleasure in doing things?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Over the last two weeks have you felt down, depressed or hopeless?
❑Not at all ❑Several days ❑More than half the days ❑Nearly every day
Do you see a counselor? ❑ **No** ❑Yes- for how long? _____ How often?_____ Name of counselor: _____
Do you feel safe at home? ❑**Yes** ❑No

Vaccinations:

Chickenpox (Varicella)	☐ No	☐ **Yes** (dates _____)	☐ Don't know
MMR-Measles, Mumps and Rubella	☐ No	☐ **Yes** (dates _____)	☐ Don't know
BCG (Tuberculosis)	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Hepatitis B	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Polio	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Hepatitis A	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Tetanus	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Influenza	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Human papilloma virus (HPV)	☐ No	☐ **Yes** (dates _____)	☐ Don't know
Other_____	☐ No	☐ **Yes** (dates _____)	☐ Don't know

Additional information:_____

_____

_____

_____

PATIENT SIGNATURE	PRINT NAME	DATE	TIME

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME

Provider Notes (for office use only)_____

_____

_____

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PLACE PATIENT LABEL HERE