University of Washington Medical Center
University Reproductive Care

ENDOCRINE HISTORY FORM

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

CONTACT INFORMATION:

First name: _____Middle initial: _____

Last name:_____

Birth date:_____Age:____Occupation:_____

Home Street Address_____

City: _____State____Zip Code: _____

Indicate which number to call or leave a message:

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

Do you feel safe at home? □ Yes □ No

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: _____

Who is your Ob/Gyn?

Name: _____Clinic: _____ Phone: (___) _____

Address: _____

What is Your Race/Ethnicity?

☐ African American
☐ American Indian/Native American
☐ Ashkenazi Jewish
☐ Asian American
☐ Cajun/French Canadian
☐ Caucasian
☐ 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_____

FEMALE 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 ☐
☐Condoms _____ ☐ Diaphragm_____ ☐ IUD_____
☐ Implanon/Nexplanon_____ ☐ Birth control pills_____
☐ Patch _____ ☐ NuvaRing_____
☐ 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_____ Number of cigarettes per day _____

Do you drink alcohol? ☐ **No** ☐ Yes

Do you need a drink to start your day? ☐ **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_____

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
- ☐ 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?_____
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

_____ DATE ___/___/____

I confirm that I have reviewed the information above.

PROVIDER SIGNATURE

_____DATE ___/___/___

Provider Notes (for office use only)_____

_____

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