

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 _____ 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

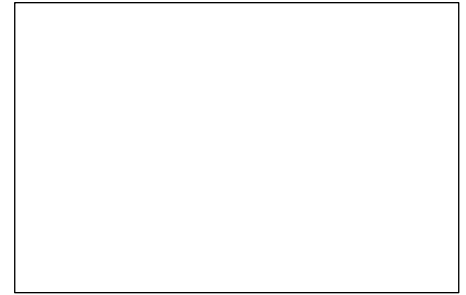
If yes, when was your last abnormal pap smear? ____/____

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 _____ Number of cigarettes per day _____

Do you drink alcohol? **No** Yes

Do you need a drink to start your day? **No** Yes

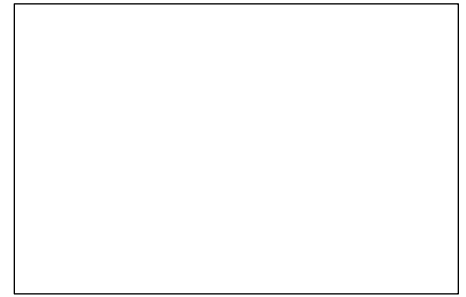
Number of drinks per week: Beer _____ Wine _____ Liquor _____

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

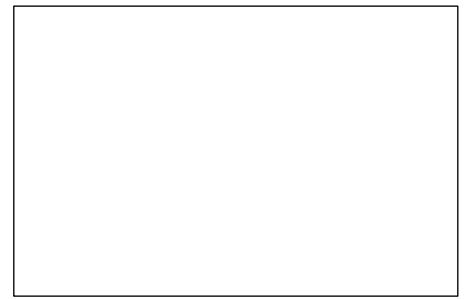
- Acne
- Excessive facial or body hair
- Cancer
- Hair loss
- Eczema
- Rash
- Other _____
- None**

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**

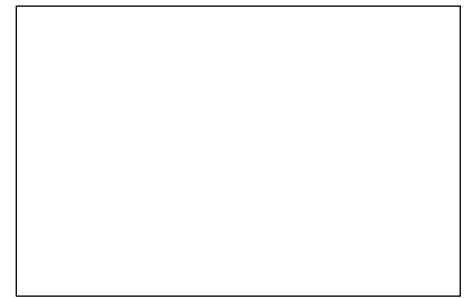
Family History	Living	Age and Cause of Death
Mother	<input type="checkbox"/> Yes-age: <input type="checkbox"/> No	
Father	<input type="checkbox"/> Yes -age: <input type="checkbox"/> No	
Brothers (number=___)	<input type="checkbox"/> Yes- ages: <input type="checkbox"/> No	
Sisters (number=___)	<input type="checkbox"/> Yes - ages: <input type="checkbox"/> No	
Maternal Grandmother	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	
Maternal Grandfather	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	
Paternal Grandmother	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	
Paternal Grandfather	<input type="checkbox"/> Yes - age: <input type="checkbox"/> No	

Disorders in Your Family

Relationship to you

- | | | | | |
|-------------------------|------------------------------|-------|-----------------------------|-------------------------------------|
| Breast Cancer | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Ovarian Cancer | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Colon Cancer | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Other Cancer _____ | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Diabetes | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Thyroid Problems | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Heart Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Blood Clots | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Psychiatric Problems | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Tuberculosis | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Endometriosis | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Menopause before age 40 | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Birth Defects | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Cystic Fibrosis | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Tay-Sachs Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Canavan Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Bloom Syndrome | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Gaucher Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |
| Niemann-Pick Disease | <input type="checkbox"/> Yes | _____ | <input type="checkbox"/> No | <input type="checkbox"/> Don't Know |

- | | | |
|--------------------------|--|---|
| Fanconi Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Familial Dysautonia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Muscular Dystrophy | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Neurologic (brain/spine) | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Neural Tube Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Bone/Skeletal Defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Dwarfism | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Developmental Delays | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Learning Problems | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Polycystic Kidneys | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Heart defect from birth | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Down Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Other Chromosome defects | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Marfan Syndrome | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Hemophilia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Sickle Cell Anemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Thalassemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Galactosemia | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Deafness/Blindness | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Color Blindness | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| Hemochromatosis | <input type="checkbox"/> Yes _____ | <input type="checkbox"/> No <input type="checkbox"/> Don't Know |
| | <input type="checkbox"/> 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) _____

