

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: _____

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: _____

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 _____

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ENDOCRINE NEW PATIENT

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UH3735 REV MAY 20

Insurance Carrier: _____

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)

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- 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

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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): _____

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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**

Endocrine/Hormonal

- Thyroid gland problems
- Diabetes
- Frequently hot or cold
- Rapid weight gain/loss
- Hot flashes
- Increased hunger/thirst
- Adrenal disorder
- Other _____
- None**

Mental Health

- Depression
- Anxiety
- Bipolar depression disorder
- Personality disorder
- Eating disorder
- Suicidal
- Other _____
- None**

Cardiovascular

- Murmurs
- Chest pain
- Heart attack
- High blood pressure
- Mitral valve prolapse
(antibiotics are required with dental procedures No Yes)
- 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**

Breasts

- Surgery (Type: _____)
- Discharge (Type: _____)
- Lumps
- Pain
- Cancer
- Other _____
- None**

Kidney/Urinary

- Kidney cysts
- Frequent bladder infections
- Kidney stones
- Blood in urine
- Frequent urination
- Other _____
- None**

Hematologic

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

Respiratory

- Shortness of breath
- Asthma
- Bronchitis
- Pneumonia Tuberculosis
- Other _____
- None**

Neurological

- Dizziness
- Weakness or loss of balance
- Seizures/Epilepsy
- Stress headaches
- Migraine headaches
- Numbness
- Memory Loss
- Other _____
- None**

Skin/extremities

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

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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 |

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- | | | |
|--------------------------|--|---|
| 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? _____ Name of counselor: _____

Do you feel safe at home? Yes No

Vaccinations:

- | | | |
|--------------------------------|--|-------------------------------------|
| Chickenpox (Varicella) | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| MMR-Measles, Mumps and Rubella | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| BCG (Tuberculosis) | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Hepatitis B | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Polio | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Hepatitis A | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Tetanus | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Influenza | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Human papilloma virus (HPV) | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |
| Other _____ | <input type="checkbox"/> No <input type="checkbox"/> Yes (dates _____) | <input type="checkbox"/> Don't know |

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Additional information: _____

PATIENT SIGNATURE	PRINT NAME	DATE	TIME
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I confirm that I have reviewed the information above.

PROVIDER SIGNATURE	PRINT NAME AND TITLE	DATE	TIME
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Provider Notes (for office use only) _____

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