University of Washington Medical Center
University Reproductive Care

MEDICAL HISTORY FORM

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

CONTACT INFORMATION:

Legal Name: ____________________ Middle Initial: ____ Last Name:___________________________

Preferred Name: ________________________ Gender Identity: __________________________

Legal sex: ____________________ Sex Assigned at Birth:_______________________________

Preferred pronouns (he/him, she/her, they/them etc) ____________________________

Date of Birth: ____/____/____ Age: _________ Occupation:_________________________________

Home Street Address:____

City: ___________________ State: _______________ Zip/Postal Code: ______________________

Indicate which number to call or leave messages

☐ Home Phone: (___) __________ ☐ Cell Phone: (___)__________☐ Work Phone:(___)__________

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

Spouse/Partner: ☐ Not Applicable

First name: ____________________ Middle Initial: ____ Last Name:___________________________

Date of Birth: ____/____/____ Age: _________ Occupation:_________________________________

Home Street Address:____

City: ___________________ State: _______________ Zip/Postal Code: ______________________

Indicate which number to call or leave messages

☐ Home Phone: (___) __________ ☐ Cell Phone: (___)__________☐ Work Phone:(___)__________

Who referred you?

☐ Physician Name: ________________________Clinic: __________________

Phone: (___)__________Address: ____

☐ Former Patient/Friend: ____

☐ Website/Advertisement: ___________________☐ Insurance Carrier:________________________

PLACE PATIENT LABEL HERE

U3904

Who is your mental health specialist?

Name: ____________________________Clinic: ________________ Phone: (___) ____________

Address: ____

Who is your primary care provider?

Name: ____________________________Clinic: ________________ Phone: (___) ____________

Address: ____

MEDICAL HISTORY AND INFORMATION:

Reason for visit? ☐ Hormone transition ☐ Hormone management ☐ Fertility preservation
☐ Other____

What is your primary goal for this visit?____
____

Do you have any personal, ethical or religious objections to any of our tests or treatments, such as insemination, in vitro fertilization, egg donation, sperm donation, masturbation to collect a semen sample, etc.?
☐ No ☐Yes ____

Menstrual History: ☐ Not applicable
Age when you had your first period: _______
Age when you first noticed breast development: _______ pubic hair: _______underarm hair: _____

Current menstrual cycle pattern: ☐ Not applicable
☐ Regular ☐ Irregular (if irregular check all that apply)
☐ <25 days ☐ >35 days ☐ No periods ☐ 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 no longer 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) ☐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 sexually active? ☐Yes ☐No
☐ Sex and/or gender of your sexual partner(s) ____
☐ Have you used over-the-counter ovulation kits to assess ovulation ? ☐No ☐Yes ☐Not applicable
☐ Do you have pain with sex? ☐**No** ☐Yes
☐ Do you use lubricants (K-Y Jelly, etc.) during sex? ☐Yes- what type? ___________ ☐ No

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

ZIKA and West Nile exposure
Have you (or your partner) traveled to a Zika Virus Zone?**:** ☐ **No** ☐ Yes
Have you (or your partner) traveled to a West Nile Zone?: ☐ **No** ☐ Yes
Do you (or your partner) plan to travel to a Zika virus or West Nile zone?**:** ☐ **No** ☐ Yes

Have you (or your partner) experienced any of the following in the last 6 months?:
Fever: ☐ **No** ☐ Yes Rash: ☐ **No** ☐ Yes Joint pain or body aches: ☐ **No** ☐ Yes
Conjunctivitis: ☐ **No** ☐ Yes Headache: ☐ **No** ☐ Yes

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 ________ ☐ Adrenal disease
☐ Pelvic inflammatory disease (PID)________ ☐ PCOS________ ☐ Thyroid disease________

Pap Smear History: ☐Not applicable
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) ☐ LEEP procedure ☐ Conization

Breast Screening History: ☐Not applicable
Do you perform breast self-exams? ☐ No ☐ Yes
Have you ever had a mammogram? ☐ No ☐ Yes – date ___/___/_____
Result: ☐ Normal ☐ Abnormal – explain ______________________

PLACE PATIENT LABEL HERE

Prostate Screening History: ☐Not applicable
Have had prostate screening? ☐ No ☐ Yes – date ___/___/___
Have you ever had a PSA test? ☐ No ☐ Yes – date ___/___/___
Result: ☐ Normal ☐ Abnormal – explain _______________________

Pregnancy Summary: ☐N/A
☐ Total Number of ALL pregnancies: __________ ☐ Number of living children ________
☐ Miscarriages (less than 20 weeks): __________ ☐ Ectopic/tubal Pregnancies: ______
☐ Elective Terminations (Abortions): __________
☐ Full Term Deliveries:________ ☐ Premature Deliveries (less than 37 weeks): _______
☐ Any Pregnancies with birth defects? ☐**No** ☐Yes ________________________________

Date Pregnancy Ended or Delivered	Months to Conception	Treatment to Conceive	Delivery Type D&C/Complications	Current Partner?
1.				☐Yes ☐No
2.				☐Yes ☐No
3.				☐Yes ☐No
4.				☐Yes ☐No

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

Drug or food	Reaction
1.	
2.	
3.	
4.	

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

Medication	Dose	Why are you taking this medication
1.		
2.		
3.		
4.		
5.		
6.		

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

Medical problem	Diagnosis date	Treatments

Surgical History: Have you had any surgeries including gender affirming surgery? ☐ **No** ☐ Yes

Year	Type of surgery and reason for surgery

Any anesthesia problems? ☐ **No** ☐ Yes (describe)____

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
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____

Review of Physical Symptoms:

General
☐ Fever/chills
☐ Recent weight gain or loss
☐ Anorexia/bulimia
☐ Lack of energy
☐ Ringing ears
☐ Other:________________
☐ **None**

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

Respiratory
☐ Shortness of breath
☐ Asthma
☐ Bronchitis
☐ Tuberculosis
☐ Pneumonia
☐ Other_________________
☐ **None**

Endocrine/Hormonal
- ☐ Thyroid gland problems
- ☐ Diabetes
- ☐ Frequently hot or cold
- ☐ 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
- ☐ 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
- ☐ Hair loss
- ☐ Rash
- ☐ Acne
- ☐ Skin cancer
- ☐ Excessive facial or body hair
- ☐ Eczema
- ☐ 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**

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

Gastrointestinal
- ☐ Ulcers
- ☐ Nausea/Vomiting
- ☐ Diarrhea ☐ Constipation
- ☐ Blood in stool
- ☐ Irritable bowel disease
- ☐ Colitis (Ulcerative or Crohn's)
- ☐ 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	

Did your mother take DES during pregnancy to prevent miscarriage? ☐ Yes ☐ **No** ☐ Don't know

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

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

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

Prior Fertility Testing and Treatment:

☐ Have you had prior fertility testing or treatment ? ☐ **No** ☐ Yes

Prior Tests: (check all that apply): ☐ **None**

☐ Basal body temperature chart (date_____/results_____________)

☐ Thyroid blood test (date_____/results_____________)

☐ Ovulation test kit (date_____/results_____________)

☐ Day 3 blood test FSH level (date_____/results_____________)

☐ AMH blood test (date_____/results_____________)

☐ Prolactin blood test (date_____/results_____________)

☐ Hysterosalpingogram (date_____/results____)

☐ Laparoscopy surgery (date_____/results____)
☐ Hysteroscopy surgery (date_____/results____)
☐ Semen analysis (date_____/results____)

Prior fertility treatment:____
____
____

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