# 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)_____

PLACE PATIENT LABEL HERE