

NORTH SEATTLE WOMEN'S GROUP

REGISTRATION FORM

PATIENT: _____ DOB: _____ AGE: _____ DATE: _____
Last Name First Name M.I.

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ MOBILE: _____

Please indicate whether it is OK to leave a detailed message on your voice mail at the above number(s): Yes ___ No ___

EMAIL ADDRESS (IF WE MAY USE IT TO CONTACT YOU): _____

REFERRED BY: _____ FAMILY DOCTOR: _____

ARE YOU INTERESTED IN PARTICIPATING IN A WOMEN'S HEALTH RESEARCH STUDY? ___ YES ___ NO

PATIENT INFORMATION

MARITAL STATUS (CIRCLE ONE): Single Married Partnered Widowed Separated Divorced GENDER: M / F
SOCIAL SECURITY #: _____ OCCUPATION: _____
EMPLOYER: _____
ARE YOU A FULL TIME STUDENT?: Y / N IF YES: SCHOOL: _____

SPOUSE INFORMATION

SPOUSE'S NAME: _____ DOB: _____
SPOUSE'S EMPLOYER: _____ OCCUPATION: _____
WORK PHONE: _____

PERSON RESPONSIBLE FOR BILL IF NOT THE PATIENT

NAME: _____ RELATIONSHIP TO PATIENT: _____
ADDRESS: _____
EMPLOYER: _____ DAYTIME PHONE #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ SECONDARY INS: _____
SUBSCRIBER NAME: _____ SUBSCRIBER NAME: _____
SUBSCRIBER DOB: _____ SUBSCRIBER DOB: _____
GROUP #: _____ GROUP #: _____
MEMBER #: _____ MEMBER #: _____
PATIENT RELATION TO SUBSCRIBER: _____ PATIENT RELATIONSHIP TO SUBSCRIBER: _____
SUBSCRIBER EMPLOYER: _____ SUBSCRIBER EMPLOYER: _____

IN CASE OF EMERGENCY, PERSON TO BE NOTIFIED (NOT AT SAME ADDRESS)

NAME: _____ RELATIONSHIP TO PATIENT: _____
HOME PHONE: _____ WORK PHONE: _____

ASSIGNMENT AND RELEASE: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN. I ALSO AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Women's Clinical Research Center
North Seattle Women's Group

Medical History Form

NAME _____ **DOB** _____ **AGE** _____ **DATE** ____/____/____
 First MI Last

How would you like to be addressed? _____ Gender: Female Male

Marital Status: Single Partnered Married Widowed Divorced Separated

Reason for visit _____

Medication (Drug)/Food Allergies		
Medication or Food	Reaction	Date first noted you had this allergy

Primary Care MD/ARNP

Name _____ Address _____ Telephone number _____

Pharmacy

Name _____ Address _____ Telephone number _____

Other Health Care Providers you have seen in the past year or see regularly (include naturopaths, etc.):

Name	Specialty	Address (include city, state, and zip)

Medications you are taking or have taken in the past 3 months (include those you buy at the drug store):

Medications and/or Vitamins	Dose (ie, 10mg)	How often? (ie, twice a day)	Start Date	Stop Date	Reason taken (ie, cholesterol)	Who prescribed it for you?	Is it working for you?
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>

SURGICAL HISTORY (including Cosmetic Surgery)

Surgery type	Date(s)	Where was it done (Hospital/City)?	Surgeon

PERSONAL HEALTH HABITS

Do you use any tobacco products? YES NO

How much per day? _____ Year started _____ Year quit _____

Do drink alcohol? YES NO Average number of drinks per week _____

Do you exercise regularly? YES NO How many hours per week: Aerobic exercise _____ Weight Training _____

Dietary Restrictions (e.g. vegan)? _____

PERSONAL AND FAMILY MEDICAL HISTORY

Condition	SELF	SELF		FAMILY	Office Use Only
	When?	Date First Diagnosed	Date Resolved	Family Member	
Neurological	None <input type="checkbox"/>				
Migraines/Headaches	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Depression	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Anxiety	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Psychiatric Care	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Epilepsy/Seizures	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Cardiovascular	None <input type="checkbox"/>				
Blood Clots	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Pulmonary Embolism	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Heart Murmur	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Irregular Heart Rate/Palpitations	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Chest Pain	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Shortness of Breath	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
High Blood Pressure	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Elevated Cholesterol	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Pulmonary	None <input type="checkbox"/>				
Asthma/Lung Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Persistent Cough	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Gastrointestinal	None <input type="checkbox"/>				
Ulcers	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hepatitis	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Liver Problems _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Gall Bladder Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Bowel Problems _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood in Stools	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Urinary Tract	None <input type="checkbox"/>				
Bladder/Kidney Infection	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Kidney Disease _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Leaking Urine	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Painful urination <input type="checkbox"/> Frequency <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Blood in Urine	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Reproductive	None <input type="checkbox"/>				
Vaginal Discharge/Odor	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Vaginal Dryness	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Painful Intercourse	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Ovarian Cyst	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Bleeding after Intercourse	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Decreased Sex Drive	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Sexually Transmitted Disease: Genital Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/> Were you treated? YES <input type="checkbox"/> NO <input type="checkbox"/>				
Musculoskeletal	None <input type="checkbox"/>				
Osteoporosis <input type="checkbox"/> Osteopenia <input type="checkbox"/>	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Osteoarthritis	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Rheumatoid Arthritis	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

Condition	SELF	SELF		FAMILY	Office Use Only
	When?	Date First Diagnosed	Date Resolved	Family Member	
Cancer: _____	None <input type="checkbox"/>				
Cancer, OTHER: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Ear, Nose, Throat	None <input type="checkbox"/>				
Eye problems	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Nose/Sinus issues	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Seasonal Allergies	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other:	None <input type="checkbox"/>				
Diabetes Mellitus	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Anemia/Blood Disorder	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Unusual Fatigue	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Change in a mole	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Thyroid Disease	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Injuries/Accidents: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Other Problems: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				

IMMUNIZATIONS (Adults without risk factors)

Do you get a flu shot yearly? YES NO Date of last tetanus shot _____ (recommended every 10 years)

Have you had a Measles/Mumps/Rubella vaccine? YES NO Have you had a varicella vaccine (or had chicken pox)? YES NO

If age 65 or over, have you had a pneumococcal vaccine? YES NO

Ever been tested for Tb? YES NO Was it positive? YES NO BCG Vaccine YES NO

Have you had the series of vaccines for HPV (Human Papilloma Virus)? YES NO

I've had: All three vaccines The first one only Two vaccines

PAP SMEAR AND CERVICAL HISTORY

Date of last PAP Smear _____ Where was it done? _____

Have you had a hysterectomy? YES NO Date of Hysterectomy: _____ Reason: _____

If so, do you have a cervix? YES NO

Were your ovaries removed? YES NO UNKNOWN ONE REMOVED: LEFT RIGHT

Ever had an ABNORMAL PAP? YES NO DATE(S): _____

Ever had a COLPOSCOPY (examining your cervix with a microscope-like instrument)? YES NO DATE(S) _____

Ever had any procedure on your cervix? (Like LEEP, Cryosurgery (freezing), Laser, Cone, etc.?) YES NO DATE(S) _____

MAMMOGRAM/BREAST HISTORY

Ever had a Mammogram? YES NO Date of last Mammogram _____

Where have you had your mammograms? _____ Results were: Normal Abnormal

Ever had an ABNORMAL Mammogram? YES NO DATE(S): _____

Ever had any procedure done on your breast(s)? YES NO Date: _____

What procedure? _____

Ever had a breast ultrasound or MRI? YES NO Where? _____

Do you have breast implants? YES NO Type: Saline Silicone When? _____

SCREENING

If age 50, Colonoscopy (View of bowels) Date _____ Where? _____ Was it normal? YES NO

Any Polyps removed? YES NO When is your next colonoscopy due? (year) _____

DEXA (Bone Scan) Date _____ Where? _____

Results: NORMAL OSTEOPENIA OSTEOPOROSIS Next DEXA Scan due (year) _____

Lipids (Cholesterol): Date _____ Diabetes testing (fasting blood sugar): Date _____ Normal? YES NO

Dental Check-up: Date _____

BIRTH CONTROL

Are you currently using ANY form of birth control? YES NO

If so, what? List all: Condoms Mirena IUS ParaGard IUD Nuvaring DepoProvera (shots) Patch Diaphragm

Pills Name of pills: _____ Vasectomy Withdrawal of penis before ejaculation Other : _____

Is this method working for you? YES NO If not, why not? _____

What have you used in the past?

List all: Condoms Mirena IUS ParaGard IUD Nuvaring DepoProvera (shots) Patch Diaphragm

Pills Name of pills: _____ Vasectomy Withdrawal of penis before ejaculation Other : _____

Why did you stop using this method? _____

Would you like information about birth control? YES NO

SEXUALITY

Have you EVER been sexually active? YES NO If yes, age at first sexual activity _____

Are you currently sexually active? YES NO If yes, do you partner with a: MALE OR FEMALE OR BOTH

Number of partners since becoming sexually active 1-2 3-5 > 5

Has anyone forced you into having sex? YES NO If yes, are you currently in a safe relationship? YES NO

Would you like more information on sexual issues? YES NO

MENSTRUAL/MENOPAUSE

How old were you when you had your first period?

First day of your last menstrual period (date): _____

Is your usual flow: HEAVY MEDIUM LIGHT How many days does your period last? _____

How many days between periods (1ST day to 1ST day)? _____

Do you bleed/spot between your periods? YES NO If so, how much and how often? _____

Do you skip periods? YES NO

Do you have cramps/pain? YES NO List any other menstrual symptoms you have: _____

Did your mother take DES? YES NO DON'T KNOW

Have you reached menopause? YES NO WHAT YEAR? _____

Have you had any bleeding since menopause? YES NO If so, when? _____

Did a health care provider evaluate the bleeding? YES NO

Are you taking Hormone Therapy? YES NO What? _____

OBSTETRIC

Have you ever been pregnant (including miscarriages and abortions)? YES NO How many times total? _____

Number of miscarriages: _____ Number of abortions _____

Number of tubal pregnancies _____ Had a molar pregnancy? YES NO

Number of multiple pregnancies (twins, triplets, etc.) _____

Number of vaginal deliveries _____ DATE(S) _____

Number of C-Section deliveries _____ DATE(S) _____

Did you deliver any of your babies early (less than 37 weeks gestation)? YES NO How many weeks early? _____

Complications during any pregnancy or delivery _____

Are you planning a pregnancy? YES NO When? _____

Have you ever had fertility treatments to help you become pregnant? YES NO DATE(S) _____

Are you currently breastfeeding? YES NO

Patient Signature _____ Date _____

Reviewed by MD/ARNP _____ Date _____
Reviewed by CRC (if applicable) _____ Date _____

Women's Clinical Research Center • North Seattle Women's Group • Menopause Center of Seattle
Lakeview Medical Dental Building
3216 NE 45th Place, Suite 100
Seattle, WA 98105
206-522-3330

Note: We are in the process of merging our three names into one.
The *new* name, "Seattle Women's Health and Research," is on the Lakeview Medical Dental Building sign.

From North or South via I-5

1. Take I-5 to the 45th Street exit.
2. Turn east onto NE 45th Street.
3. Continue on NE 45th Street past the University of Washington and down the hill.
4. Turn left at the stoplight and continue on NE 45th Street past University Village to the 5-way intersection. There are two left turn lanes – choose the one on the right.
5. Take a soft left onto NE 45th Place (in front of Baskin Robbins).
6. Take an immediate left into one of the two parking lots at the Lakeview Medical Dental Building. We are on the ground floor in Suite #100.

From East via 520

1. Take the Montlake Blvd North exit.
2. Merge onto Montlake Blvd. E.
3. Follow Montlake Blvd. as it curves to the east, merge onto NE 45th Street.
4. Continue on NE 45th Street past University Village to the 5-way intersection. There are two left turn lanes – choose the one on the right.
5. Take a soft left onto NE 45th Place (in front of Baskin Robbins).
6. Take an immediate left into one of the two parking lots at the Lakeview Medical Dental Building. We are on the ground floor in Suite #100.

Via Seattle Metro Transit (plan your trip at <http://transit.metrokc.gov>):
Bus routes 25, 65, and 75 all have stops within a block of our building.

