

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: _____

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

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. ← to I-5 ↓

