WOMEN'S CLINICAL RESEARCH CENTER
"Research for women, by women"

Research Participant Registration Form

Patient: ____ Date: ____________________
Last Name First Name M.I.

Address: ______________________________City: ______________State: _______Zip:________

Home phone: ____________________ Work phone: ____________________ Mobile: ____________________

Email Address: ______________________________ Date of Birth: _____/_____/_______Age: ________
month day year

Social Security # (Why are we asking for this?*): _________-________-____________

Would you like to be kept informed about upcoming research studies at WCRC?

☐ Yes, please keep me active in your database!
☐ No, please do not contact me in the future.

Are you a student? **yes / no** If yes, which school? ____

Occupation: __________________________ Employer: ________________________________

Check all of the following that apply:

OK to leave a detailed message:

☐ on voicemail at home # ☐ on voicemail at work #
☐ on mobile # ☐ at a different phone #: __________________________

OK to leave information with:

☐ Spouse/partner (name): ____
☐ Other family member (relationship & name): ______________________________

How did you hear about us? Circle all that apply:

- Friend/Co-worker - Name (so we can thank them)_______________________
- Craigslist.org
- Word of mouth
- Website, if so which one? _________________________
- Print ad, if so which paper? ________________________
- Radio ad, if so which station? ______________________
- Other ____

In Case Of Emergency - Person To Be Notified

Name:________________________________Relationship To Patient: ______________________

Home Phone: ________________________________Work Phone: ____________________________

Signature:____Date: ____________________

*IRS requires that businesses report all payments made to each person to whom they have paid at least $600 in other income during the course of one year on form **1099-MISC** (Miscellaneous Income). Social Security # and current address are required in order to report.

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 ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐
							Yes ☐ No ☐

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

Patient Name_________________________________

	SELF	SELF		FAMILY	
Condition	**When?**	**Date First Diagnosed**	**Date Resolved**	**Family Member**	**Office Use Only**
Cancer:_____________________	**None ☐**				
Cancer, OTHER:____________	Now ☐ In the past ☐				
Ear, Nose, Throat	**None ☐**				
Eye problems	Now ☐ In the past ☐				
Nose/Sinus issues	Now ☐ In the past ☐				
Seasonal Allergies	Now ☐ In the past ☐				
Other:	**None ☐**				
Diabetes Mellitus	Now ☐ In the past ☐				
Anemia/Blood Disorder	Now ☐ In the past ☐				
Unusual Fatigue	Now ☐ In the past ☐				
Change in a mole	Now ☐ In the past ☐				
Thyroid Disease	Now ☐ In the past ☐				
Injuries/Accidents:_________	Now ☐ In the past ☐				
Other Problems: __________ ___________________________	Now ☐ In the past ☐				

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 ________

Patient Name_____________________________

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 ____________________

Patient Name______________________________

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.