

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.

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 ↓

