



# Seattle Reproductive Medicine<sup>®</sup>

A N I N T E G R A M E D<sup>®</sup> A F F I L I A T E

## MEDICAL AND REPRODUCTIVE HISTORY—ENDOCRINE

Today's date \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of appointment \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT:**

**(Legal)** Last name: \_\_\_\_\_ **(Legal)** First name: \_\_\_\_\_ Middle initial \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_

Marital Status: \_\_\_\_single \_\_\_\_married \_\_\_\_divorced \_\_\_\_widowed Length of Relationship: \_\_\_\_years

**MAILING ADDRESS:**

Street: \_\_\_\_\_ City: \_\_\_\_\_

State/Providence: \_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_ Country: \_\_\_\_\_

Home Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_ OK to leave message? Best # to reach you:  
 Yes  No

Work Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Yes  No

Cell Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_  Yes  No

Email Address: \_\_\_\_\_

**How did you hear about SRM?**

- Family/Friend
- Internet
- Radio
- Other Advertising
- Physician's Office (Name) \_\_\_\_\_

**Who is your regular healthcare provider?**

- A. Primary Care Provider: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- B. OB/Gyn (if other than A)  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Did a physician or other healthcare provider refer you to SRM?**

- Yes  No

If so, whom?

- PCP \_\_\_\_\_
- OB/Gyn \_\_\_\_\_
- Other \_\_\_\_\_

**Do you wish SRM to send copies of your medical notes to this referring provider?**

- Yes  No
- Yes  No
- Yes  No

## REPRODUCTIVE HEALTH HISTORY

**MENSTRUAL AND PUBERTAL HISTORY:**

Age when you had your first menstrual period: \_\_\_\_\_ years old

Age when you developed pubic and/or axillary (armpit) hair: \_\_\_\_\_ years old

Age when you began breast development: \_\_\_\_\_ years old

If you do not have any periods, at what age did you stop having them? \_\_\_\_\_ years old \_\_\_\_\_ never started

The first day of your last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_

Menstrual cycle pattern **during first 2 years** after your first menstrual period (check all that apply):

- Regular periods                       Irregular periods                       No periods  
 Spotting between periods                       Heavy periods                       Light periods

*Current* menstrual cycle pattern (check all that apply):

- Regular periods                       Irregular periods                       No periods  
 Spotting between periods                       Heavy periods                       Light periods

How many days of bleeding do you usually have? \_\_\_\_\_ days

How many days from the first day of one period to the first day of the next? \_\_\_\_\_ days

Do you need medication to bring on a period? \_\_\_\_\_ If yes, what type? \_\_\_\_\_

Do you have cramping or pelvic pain with your periods? (check one)

- Always       Sometimes       Recently       In the past       No

Degree of pain (1 to 10, with 10 being most severe): \_\_\_\_\_

Over the past few years, is the pain:     getting better     getting worse     staying the same

**PREGNANCY HISTORY:** List all pregnancies, specifying under outcome whether liveborn, stillborn, ectopic, miscarriage or abortion.

Pregnancy #	Preg. Ended (mo./yr.)	Preg. Length (weeks, months)	Outcome	FATHER ( check one )	
				Present partner	Previous partner

**REPRODUCTIVE HEALTH HISTORY (continued)**

Have you ever had an abnormal pap smear? If "Yes," please describe: \_\_\_\_\_

When was your last pap smear? \_\_\_\_/\_\_\_\_/\_\_\_\_ Was it normal? \_\_\_\_ Yes \_\_\_\_ No

Did your mother take DES while pregnant with you? \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ Don't know

Have you ever had a mammogram? \_\_\_\_ Yes \_\_\_\_ No If yes, when was the last one? \_\_\_\_/\_\_\_\_/\_\_\_\_

**SEXUAL HISTORY**

Are you currently sexually active with a male partner? \_\_\_\_ Yes \_\_\_\_ No Female partner? \_\_\_\_ Yes \_\_\_\_ No

Duration of current relationship: \_\_\_\_\_

How old were you when you first had intercourse? \_\_\_\_ years old \_\_\_\_ never (skip to next section)

Time since contraception last used? \_\_\_\_\_

Are you currently trying to become pregnant? \_\_\_\_ Yes \_\_\_\_ No

If you previously have been pregnant, how long has it been since the most recent pregnancy? \_\_\_\_\_

Have you ever been unable to conceive for a year or more? \_\_\_\_ Yes \_\_\_\_ No

Do have pain with intercourse? \_\_\_\_\_

Have you ever had any sexually transmitted diseases? (please check all that apply)

- |                                    |  |                                      |                                |
|------------------------------------|--|--------------------------------------|--------------------------------|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea     | <input type="checkbox"/> Herpes      | <input type="checkbox"/> Other |
| <input type="checkbox"/> Syphilis  | <input type="checkbox"/> Genital Warts | <input type="checkbox"/> Trichomonas | _____                          |
| <input type="checkbox"/> HIV       | <input type="checkbox"/> HPV           | <input type="checkbox"/> Hepatitis   |                                |

Have you every had pelvic inflammatory disease? \_\_\_\_ Yes \_\_\_\_ No

If yes, when? \_\_\_\_\_ Were you hospitalized? \_\_\_\_\_

**CONTRACEPTIVE METHOD HISTORY:**

Type	Years Used
<input type="checkbox"/> Birth Control Pill / Patch	
<input type="checkbox"/> Depo-Provera, Lunelle	
<input type="checkbox"/> Norplant	
<input type="checkbox"/> Diaphragm	
<input type="checkbox"/> IUD	
<input type="checkbox"/> Condoms	
<input type="checkbox"/> Tubal Sterilization	
<input type="checkbox"/> Vasectomy	
<input type="checkbox"/> Rhythm (natural method)	
<input type="checkbox"/> Other	

**PREVIOUS ENDOCRINE EVALUATION AND TREATMENT**

**PREVIOUS ENDOCRINE EVALUATION:**

**Have you had any of the following tests performed?**

<u>Test:</u>			<u>Date</u>	<u>Result normal?</u>		<u>If no, describe:</u>
	Yes	No		Yes	No	
Day 3 FSH level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Progesterone level(s)	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endometrial biopsy	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prolactin blood test	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fasting blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insulin level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____
Testosterone level	<input type="checkbox"/>	<input type="checkbox"/>	___/___/___	<input type="checkbox"/>	<input type="checkbox"/>	_____

**PREVIOUS TREATMENT:**

Please indicate if you have ever been treated with the following for non-contraceptive reasons:

<u>Medication</u>	<u>Type/Years Used and Result</u>
<input type="checkbox"/> Birth Control Pill/Patch	
<input type="checkbox"/> Provera [depot (IM) or oral]	
<input type="checkbox"/> Lunelle	
<input type="checkbox"/> Depo-Lupron	
<input type="checkbox"/> Danazol	
<input type="checkbox"/> Clomiphene (clomid, serophene)	
<input type="checkbox"/> Gonadotropins (Pergonal, Gonal-F, Follistim, Repronex, Metrodin, etc)	
<input type="checkbox"/> Estrogen (premarin, estrace, patch)	
<input type="checkbox"/> Bromocriptine or dostinex	
<input type="checkbox"/> Thyroid replacement	
<input type="checkbox"/> Dexamethasone, prednisone, or cortisone	
<input type="checkbox"/> Metformin (glucophage)	
<input type="checkbox"/> Avandia (rosiglitazone)	
<input type="checkbox"/> Spironolactone (aldactone)	
<input type="checkbox"/> Other	

**GENERAL MEDICAL HISTORY**

What is your current weight? \_\_\_\_\_ Height? \_\_\_\_\_ Usual weight? \_\_\_\_\_

Recent weight loss or gain? \_\_\_\_\_

Approximately how much did you weigh at age 18? \_\_\_\_\_ 25? \_\_\_\_\_ 30? \_\_\_\_\_ 35? \_\_\_\_\_ 40? \_\_\_\_\_

Check any of the following that have been a problem for you during the past 6 months:

Eye problems	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Nausea, vomiting	<input type="checkbox"/>
Stuffy nose, hay fever	<input type="checkbox"/>	Shaking, tremor	<input type="checkbox"/>	Constipation, diarrhea	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	Dizziness, fainting	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Fevers, sweats, chills	<input type="checkbox"/>	Hernia	<input type="checkbox"/>
Easy bleeding or bruising	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	Frequent urination at night	<input type="checkbox"/>
Enlarged or painful breasts	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Vaginal discharge, itching or pain	<input type="checkbox"/>
Discharge from nipples	<input type="checkbox"/>	Low energy	<input type="checkbox"/>	Pelvic Pain	<input type="checkbox"/>
Breast lumps	<input type="checkbox"/>	Heart burn, indigestion	<input type="checkbox"/>	Sexual problems	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Gas, cramps, pains	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>
Fast or irregular heartbeat	<input type="checkbox"/>	Blood in stool or black stool	<input type="checkbox"/>	Temperature intolerance	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	Dark skin on neck, armpits	<input type="checkbox"/>	Hair thinning or loss	<input type="checkbox"/>
Excessive face or body hair	<input type="checkbox"/>	Acne or pimples	<input type="checkbox"/>		

Please describe any checked boxes: \_\_\_\_\_

**ALLERGIES:**

Latex? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, specify reaction: \_\_\_\_\_

Iodine or seafood? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, specify reaction: \_\_\_\_\_

Medications? \_\_\_\_\_ Yes \_\_\_\_\_ No Which meds, specify reaction: \_\_\_\_\_

**GENERAL MEDICAL HISTORY (Continued)**

Please indicate which of the following applies to you now or in the past:

Breast disease	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Psychiatric illness	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Ovarian Tumor	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	Bladder/kidney disease	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Herpes (oral)	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	Elevated prolactin	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Adrenal Hyperplasia	<input type="checkbox"/>	Rubella (German Measles)	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Birth defects	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	Neurologic disease	<input type="checkbox"/>	Past history of IV drug use	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Bulimia or anorexia	<input type="checkbox"/>

Other disorder: \_\_\_\_\_

Please explain any positive responses:

\_\_\_\_\_

\_\_\_\_\_

**SURGICAL HISTORY:**

Please list any major surgeries or hospitalizations in the table below. Include abortions, ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

**MEDICATIONS:**

Please list all medications or treatments you are currently taking: (please include any over-the counter or herbal drug.

Medication	Dosage	Frequency	Reason

## FAMILY HEALTH HISTORY

Are there any known genetic diseases or conditions that run in your family? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, which one(s) and whom? \_\_\_\_\_

Are there any members of your family with birth defects, such as heart defect, mental retardation, neural tube defect (e.g., spina bifida), or other? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you adopted? \_\_\_\_\_ Yes \_\_\_\_\_ No

Ethnic Background: \_\_\_\_\_

**Are any of your blood relatives of the following ethnic group?**

**Risk increased for:**

- |                                |           |          |                                 |
|--------------------------------|-----------|----------|---------------------------------|
| Caucasian                      | _____ Yes | _____ No | Cystic Fibrosis                 |
| English                        | _____ Yes | _____ No | Neural Tube Defects             |
| Mediterranean (Greek, Italian) | _____ Yes | _____ No | Thalassemia                     |
| Ashkenazi Jewish               | _____ Yes | _____ No | Tay Sachs, Canavan              |
| French Canadian                | _____ Yes | _____ No | Tay Sachs                       |
| Southeast Asian                | _____ Yes | _____ No | Thalassemia                     |
| African descent                | _____ Yes | _____ No | Sickle Cell Anemia, Thalassemia |

Please indicate whether any of your blood relatives have had any of the following conditions:

MEDICAL PROBLEM	PARENTS		SIBLINGS		MATERNAL		PATERNAL		YOUR Children	OTHER Relatives
	M	F	Sisters	Brothers	GF	GM	GF	GM		
Diabetes										
Cancer (specify)										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Stroke										
Cystic Fibrosis										
Clotting or bleeding disorder										
Sickle cell anemia										
Thalassemia										
Other serious health issues										

Please explain any positive answers:

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**SOCIAL HISTORY**

Current Occupation: \_\_\_\_\_

Prior Occupation(s): \_\_\_\_\_

Have you or do you use any of the following?

	Never	Not in the Last 3 months	Yes	List amount, type and frequency (how often-per day/per week)
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Social drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

EMOTIONAL STATUS:

On a scale of 1 to 10, (10 being the highest) what do you estimate your average level of stress to be? \_\_\_\_\_

Were there times during the past month when you experienced little interest in doing things? \_\_\_\_\_ Yes \_\_\_\_\_ No

In the past month, have there been times when you felt down, depressed, or hopeless? \_\_\_\_\_ Yes \_\_\_\_\_ No