



# 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

**FEMALE PATIENT:**

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

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

Marital Status: \_\_\_\_single \_\_\_\_married \_\_\_\_domestic partner Length of Relationship: \_\_\_\_years

Legal Guardian (if patient is a minor): \_\_\_\_\_

**MAILING ADDRESS:**

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

State/Province: \_\_\_\_\_ 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
- Medical office/physician referral (Name) \_\_\_\_\_
- Other \_\_\_\_\_

Would you like medical notes sent to your other healthcare provider?

- Yes
- No

If yes, please indicate which provider(s) you would like us to send medical notes to:

Provider name	Address	Please indicate provider type:		
		Primary care	OB/Gyn	Other

Reason for visit: \_\_\_\_\_

## REPRODUCTIVE HEALTH HISTORY

### MENSTRUAL AND PUBERTAL HISTORY

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

The first day of your most recent menstrual period: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Regular periods          | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> No periods    |
| <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Heavy periods     | <input type="checkbox"/> Light periods |

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Regular periods          | <input type="checkbox"/> Irregular period | <input type="checkbox"/> No periods    |
| <input type="checkbox"/> Spotting between periods | <input type="checkbox"/> Heavy periods    | <input type="checkbox"/> Light periods |

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

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

Do you need medication to bring on a period?  Yes  No 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

If you do not have periods, at what age did you stop having them? \_\_\_\_\_ years old

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

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

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

Have you ever had an abnormal Pap smear?  Yes  No If "Yes," date and treatment: \_\_\_\_\_

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? \_\_\_\_ / \_\_\_\_

Was your mammogram normal?  Yes  No

**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

Any pain with intercourse?  Yes  No

Do you regularly use lubricant with intercourse?  Yes  No If yes, what type? \_\_\_\_\_

Have you ever had any sexually transmitted infections? (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 ever had pelvic inflammatory disease?  Yes  No

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

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

**CONTRACEPTIVE METHOD HISTORY:**

Type	Years Used
<input type="checkbox"/> Birth Control Pill / Patch	
<input type="checkbox"/> Depo-Provera, Lunelle	
<input type="checkbox"/> Nuva Ring	
<input type="checkbox"/> Norplant/Implanon	
<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	

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

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

**PREVIOUS ENDOCRINE EVALUATION:**

Have you had any of the following tests performed?

Test:			Date	Result normal?		If no, describe:
	Yes	No		Yes	No	
LH/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:

Medication	Type/Years Used and Result
<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)/Actos(pioglitazone)	
<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 in the past 6 months? \_\_\_\_\_

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

Are you currently being treated or being seen for any medical condition(s)?  Yes  No  
 If yes, please describe: \_\_\_\_\_

**REVIEW OF SYSTEMS:**

Check any of the following that you are presently having or have had in the past:

- |   |  |   |
|---|--|---|
| <u>Eye problems</u> <input type="checkbox"/>                  | <u>Gall bladder problems</u> <input type="checkbox"/>          | <u>Excessive thirst</u> <input type="checkbox"/>            |
| <u>Stuffy nose, hay fever</u> <input type="checkbox"/>        | <u>Liver disease</u> <input type="checkbox"/>                  | <u>Temperature intolerance</u> <input type="checkbox"/>     |
| <u>Frequent nose bleeds</u> <input type="checkbox"/>          | <u>Frequent urination at night</u> <input type="checkbox"/>    | <u>Headaches</u> <input type="checkbox"/>                   |
| <u>Fast or irregular heartbeat</u> <input type="checkbox"/>   | <u>Vaginal discharge,itching,pain</u> <input type="checkbox"/> | <u>Shaking, tremor</u> <input type="checkbox"/>             |
| <u>Heart murmur</u> <input type="checkbox"/>                  | <u>Pelvic pain</u> <input type="checkbox"/>                    | <u>Anxiety</u> <input type="checkbox"/>                     |
| <u>Mitral valve prolapse</u> <input type="checkbox"/>         | <u>Sexual problems</u> <input type="checkbox"/>                | <u>Depression</u> <input type="checkbox"/>                  |
| <u>Dizziness, fainting</u> <input type="checkbox"/>           | <u>Endometriosis</u> <input type="checkbox"/>                  | <u>Bulimia or anorexia</u> <input type="checkbox"/>         |
| <u>Shortness of breath</u> <input type="checkbox"/>           | <u>Ovarian tumor</u> <input type="checkbox"/>                  | <u>Anemia</u> <input type="checkbox"/>                      |
| <u>Lung disease</u> <input type="checkbox"/>                  | <u>Dark skin on neck, armpits</u> <input type="checkbox"/>     | <u>Easy bleeding or bruising</u> <input type="checkbox"/>   |
| <u>Asthma</u> <input type="checkbox"/>                        | <u>Acne or pimples</u> <input type="checkbox"/>                | <u>Poor circulation</u> <input type="checkbox"/>            |
| <u>Tuberculosis</u> <input type="checkbox"/>                  | <u>Enlarged or painful breasts</u> <input type="checkbox"/>    | <u>Blood transfusion</u> <input type="checkbox"/>           |
| <u>Heartburn, indigestion</u> <input type="checkbox"/>        | <u>Discharge from nipples</u> <input type="checkbox"/>         | <u>Fatigue</u> <input type="checkbox"/>                     |
| <u>Gas, cramps, pain</u> <input type="checkbox"/>             | <u>Breast lumps</u> <input type="checkbox"/>                   | <u>Low energy</u> <input type="checkbox"/>                  |
| <br>  |  |   |
| <u>Blood in stool or black stool</u> <input type="checkbox"/> | <u>Breast disease</u> <input type="checkbox"/>                 | <u>Past history of IV drug use</u> <input type="checkbox"/> |
| <u>Nausea, vomiting</u> <input type="checkbox"/>              | <u>Hot flashes</u> <input type="checkbox"/>                    | <u>Rubella (German Measles)</u> <input type="checkbox"/>    |
| <u>Constipation</u> <input type="checkbox"/>                  | <u>Excessive face or body hair</u> <input type="checkbox"/>    | <u>Other</u> <input type="checkbox"/>                       |
| <u>Diarrhea</u> <input type="checkbox"/>                      | <u>Hair thinning or loss</u> <input type="checkbox"/>          | _____ <input type="checkbox"/>                              |
| <u>Hernia</u> <input type="checkbox"/>                        | <u>Fever, sweats, chills</u> <input type="checkbox"/>          | _____ <input type="checkbox"/>                              |

Please explain any positive responses:  
 \_\_\_\_\_  
 \_\_\_\_\_

**ALLERGIES:**

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

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

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

**SURGICAL HISTORY:**

Please list any major surgeries or hospitalizations in the table below. Include elective termination (abortion), ectopic pregnancy, tubal surgery or any other surgeries:

	Mo. / Year	Procedure	Reason
1			
2			
3			
4			

**MEDICATIONS INCLUDING: VITAMINS / HERBS / OVER THE COUNTER MEDICATION (OTC'S)**

Please list all medications or treatments you are currently taking:

Medication	Dosage	Frequency	Reason	Start Date

### 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? \_\_\_\_\_

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

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

### FAMILY AND GENETIC 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 defects (e.g. spina bifida) or other? Yes No

Are you adopted? Yes No

Ethnic background: \_\_\_\_\_

**Please indicate which of the following conditions may be found in your family:**

MEDICAL PROBLEM	Yourself	PARENTS		SIBLINGS		MATERNAL GRANDPARENTS		PATERNAL GRANDPARENTS		YOUR Children	OTHER Relatives
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF		
Neural tube defects (spina bifida, "open spine", anencephaly)											
Heart defects ("hole in the heart", etc.)											
Any birth defects requiring surgery (cleft lip, etc.)											
Unusual genitals in boys or girls											
Limb defects (missing or extra fingers, toes, shorten arms or legs)											
Diabetes											
Blindness											
Deafness											
Bone disorders											
Skin Diseases (eczema, melanoma)											
Hydrocephaly ("water on the brain")											
Cancer before age 50 (specify)											
Heart Disease											
Kidney Disease											
High Blood Pressure											
High Cholesterol											
Stroke											
Epilepsy (seizures)											
Urinary Tract abnormalities											
Clotting disorders (Factor V Leiden, etc.)											
Bleeding disorders (hemophilia, etc.)											
Thalassemia (Cooley's anemia)											
Women who have had multiple miscarriages											
Stillbirth or children who have died as infants											
Mental Illness (schizophrenia, bipolar, etc)											
Mental retardation, autism or learning disabilities											
Neurologic or neurodegenerative diseases (Alzheimer, Huntington, etc)											
Endocrine Disorders (adrenal gland, parathyroid, thyroid disorder, Adrenal Hyperplasia)											
Neuromuscular diseases (muscular dystrophies, etc.)											
Other genetic disorders (Cystic fibrosis, marfan syndrome, neurofibromatosis, sickle cell anemia, PKU, Tay-Sachs disease, Canavan disease, etc.)											
Chromosome Problems (Down syndrome, Klinefelter syndrome)											

Please explain any positive answers: \_\_\_\_\_

\_\_\_\_\_