Seattle Women's
HEALTH • RESEARCH • GYNECOLOGY

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Please do NOT print double sided & use black or blue ink

INTAKE FORM

NAME _____ **DOB**_____ **AGE** _____ **DATE**____ /____ /____
First MI Last

How would you like to be addressed? _____ Gender: Female☐ Male☐

Primary Care _____
Name Address Telephone number

Pharmacy _____
Name Address Telephone number

Reason for visit: _____

If the reason for your visit is a STUDY, please initial the following statement:

____ I am currently *not* participating in any other clinical trials at other locations

MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Dermatological (Skin)	**None ☐**				
Precancer/Cancer	Now ☐ In the past ☐				
Rash	Now ☐ In the past ☐				
Abnormal mole	Now ☐ In the past ☐				
Other skin conditions: _____	Now ☐ In the past ☐				
Neurological (Nervous system)	**None ☐**				
Migraines / Headaches	Now ☐ In the past ☐				
Depression	Now ☐ In the past ☐				
Anxiety	Now ☐ In the past ☐				
Psychiatric Care/ Hospitalization	Now ☐ In the past ☐				
Epilepsy/Seizures	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Cardiovascular (Heart & blood)	**None ☐**				
Heart Murmur	Now ☐ In the past ☐				
Irregular Heart Rate/Palpitations	Now ☐ In the past ☐				
Chest Pain	Now ☐ In the past ☐				
Heart Attack	Now ☐ In the past ☐				
High Blood Pressure	Now ☐ In the past ☐				
Elevated Cholesterol	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Pulmonary (Lungs)	**None ☐**				
Asthma	Now ☐ In the past ☐				

COPD	Now ☐ In the past ☐				
Persistent Cough	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Gastrointestinal (Digestion)	**None ☐**				
Ulcers	Now ☐ In the past ☐				
Hepatitis / Liver Problems	Now ☐ In the past ☐				
Gall Bladder Disease	Now ☐ In the past ☐				
Heartburn/GERD	Now ☐ In the past ☐				
Chronic Constipation	Now ☐ In the past ☐				
Diarrhea	Now ☐ In the past ☐				
Persistent Nausea ☐ Vomiting ☐	Now ☐ In the past ☐				
Blood in Stool	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Urologic (Kidneys & Bladder)	**None ☐**				
Frequent Urinary Tract Infection	Now ☐ In the past ☐				
Kidney Infection	Now ☐ In the past ☐				
Kidney Disease	Now ☐ In the past ☐				
Bladder Problems Incontinence (leaking) Urinary Frequency Urinary Urgency	 Now ☐ In the past ☐ Now ☐ In the past ☐ Now ☐ In the past ☐				
Blood in Urine	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Musculoskeletal(Muscles& Bones)	**None ☐**				
Osteoporosis ☐ Osteopenia ☐	Now ☐ In the past ☐				
Arthritis: Type_____	Now ☐ In the past ☐				
Fibromyalgia	Now ☐ In the past ☐				
Fractures	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Eyes, Ear, Nose, Throat	**None ☐**				
Glaucoma -Type _____	Now ☐ In the past ☐				
Hearing Problems	Now ☐ In the past ☐				
Seasonal Allergies/Hay Fever	Now ☐ In the past ☐				
Cataracts	Now ☐ In the past ☐				
Other eye problems: _____	Now ☐ In the past ☐				
Current dental issues?	Yes ☐ No ☐				
Other:_____	Now ☐ In the past ☐				
Endocrine (Glands)	**None ☐**				
Diabetes Mellitus: Type I or II	Now ☐ In the past ☐				
Thyroid Disease	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Hematology (Blood Disorders)	**None ☐**				
Anemia	Now ☐ In the past ☐				
Blood Clots / Pulmonary Embolism	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				
Lupus/ SLE	Now ☐ In the past ☐				
Cancer	**None ☐**				
Cancer Type:_____	Now ☐ In the past ☐				
Cancer Type:_____	Now ☐ In the past ☐				
Cancer Type:_____	Now ☐ In the past ☐				
Cancer Type:_____	Now ☐ In the past ☐				

SURGICAL HISTORY (Including Cosmetic Surgery)

Surgery type	Date(s)	Reason	Where was it done (Hospital/City)?

FAMILY MEDICAL HISTORY

Relative	Living ?	Major Medical Problems (i.e. stroke, heart attack)
Mother		
Father		
Siblings		
Siblings		
Siblings		
Other		

CURRENT MEDICATIONS

Medications you are taking currently (include those you buy at the drug store, health food store)					
Medications, Vitamins, and/or Health supplements	Dose (e.g. 10mg)	How often? (e.g. twice a day)	Start Date	Stop Date (If applicable)	Reason taken (e.g. cholesterol)
Other Medications you have taken in the past 3 months					

MEDICATION(DRUG) / FOOD ALLERGIES

Medication or Food	Reaction	Date you first had this reaction

PERSONAL HEALTH HABITS

Occupation:_____ Single☐ Partnered☐ Married☐ Widowed☐ Divorced☐ Separated☐
Tobacco use? How much per day? _____ Year started_____ Year quit _____
Alcohol use? YES ☐ NO ☐ Average number of drinks per week _____
Current or past history of substance abuse? YES ☐ NO ☐ Dates:_____
Do you exercise? _____ How often? _____ Any dietary restrictions? _____

IMMUNIZATIONS

Yearly flu shot? 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☐

FEMALES:

OBSTETRIC HISTORY (PREGNANCY)

Date	Type of Delivery	Complications of pregnancy

OTHER PREGNANCIES- MISCARRAGES/ ABORTIONS/ ECTOPICS

Date	Outcome

GYNECOLOGICAL HISTORY

Last Menstrual Period:	Method of Birth Control:
Age of 1st menstrual period:	
Menses last_____ days and come every _____ days : _____heavy _____medium _____light	
Last Pap:	If any abnormal paps, when and how was it treated:
Last mammogram:	Where:
Any abnormal mammograms and when:	
Breast procedures/ Ultrasound/ MRI?	
Breast Implants? Type:	
Lifetime sexual partners _____ 1-5 _____ 6-20 _____ > 20	

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Genital Infections: ☐ Bacterial Vaginosis ☐ Gonorrhea ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Other:_____					
Uterine fibroids	Now ☐ In the past ☐				
Ovarian Cyst	Now ☐ In the past ☐				
Vaginal Dryness	Now ☐ In the past ☐				
Decreased Sex Drive	Now ☐ In the past ☐				
Painful intercourse	Now ☐ In the past ☐				
Irregular Bleeding	Now ☐ In the past ☐				
Painful Periods	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				

MALES:

Condition	When?	Date First Diagnosed	Date Resolved	Taking Medication?	Office Use Only
Reproductive	**None ☐**				
Genital Infections: ☐ Bacterial Vaginosis ☐ Gonorrhea ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Other:_____					
Prostate Problems	Now ☐ In the past ☐				
Decreased Sex Drive	Now ☐ In the past ☐				
Erectile Dysfunction	Now ☐ In the past ☐				
Other:_____	Now ☐ In the past ☐				

Patient Signature _____ Date _____

Reviewed by **Provider:** _____ Date _____

Reviewed by **CRC** (if applicable) _____Date _____