



Robin Kroll, MD, FACOG

Irene M. Piekarski, MD

Susan Vendeland, MN, ARNP

**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?\*) : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*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.

We may occasionally contact you to ask if you would like to participate in future women's health research studies in this office. If you would like to opt out of this opportunity, please check here:

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? Check all that apply:**

- Patient of our medical practice  Print Ad: \_\_\_\_\_  
 Previous study participant/screen  Radio Ad: \_\_\_\_\_  
 Craigslist  Facebook  
 Website: \_\_\_\_\_  Social Media: \_\_\_\_\_  
 Friend/Family/Co-worker (Name, so we can thank them: \_\_\_\_\_)  
 Other: \_\_\_\_\_

**In Case Of Emergency - Person To Be Notified**

Name: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_



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**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 (e.g. 10mg)	How often? (e.g. twice a day)	Start Date	Stop Date	Reason taken (e.g. cholesterol)	Who prescribed it for you?	Is it working for you?
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>
							Yes <input type="checkbox"/> No <input type="checkbox"/>

**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)? \_\_\_\_\_

**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

**PERSONAL AND FAMILY MEDICAL HISTORY**

Condition	SELF	SELF		FAMILY	Office Use Only
	When?	Date First Diagnosed	Date Resolved	Family Member	
<b>Dermatological</b>	<b>None <input type="checkbox"/></b>				
Rashes	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Change in a mole	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Neurological</b>	<b>None <input type="checkbox"/></b>				
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"/>				
<b>Cardiovascular</b>	<b>None <input type="checkbox"/></b>				
Blood Clots / 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"/>				
<b>Pulmonary</b>	<b>None <input type="checkbox"/></b>				
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"/>				
<b>Gastrointestinal</b>	<b>None <input type="checkbox"/></b>				
Ulcers	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
Hepatitis / 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"/>				
<b>Urinary Tract</b>	<b>None <input type="checkbox"/></b>				
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"/>				
<b>Musculoskeletal</b>	<b>None <input type="checkbox"/></b>				
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"/>				
<b>Ear, Nose, Throat</b>	<b>None <input type="checkbox"/></b>				
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"/>				
Contact Lens	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Reproductive</b>	<b>None <input type="checkbox"/></b>				
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"/>				

Condition	SELF	SELF		FAMILY	Office Use Only
	When?	Date First Diagnosed	Date Resolved	Family Member	
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"/>				
<b>Cancer:</b> _____	<b>None</b> <input type="checkbox"/>				
Cancer, OTHER: _____	Now <input type="checkbox"/> In the past <input type="checkbox"/>				
<b>Other:</b> _____	<b>None</b> <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"/>				
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"/>				

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

### 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

### 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

### 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

### 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

### 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 (1<sup>ST</sup> day to 1<sup>ST</sup> 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? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by MD/ARNP \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by CRC (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

### Map and Directions

#### 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 Robins)
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 the 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

1. Plan your trip at <http://metro.kingcounty.gov/>
2. Bus routes 25, 65, and 75 all have stops within one block of our building.

