Seattle Women's
HEALTH • RESEARCH • GYNECOLOGY®

Lakeview Medical Dental Building
3216 NE 45th Place, Suite 100
Seattle, WA 98105

Phone: 206-522-3330
Fax: 206-522-8594
www.SeattleWomens.com

Robin Kroll, MD, FACOG   Shan Hoekman, CNM, ARNP

Research Participant Registration Form

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

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.*

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:** ____________

Seattle Women's: Health, Research, Gynecology® is dedicated to providing exemplary health care for women of all ages. We offer a unique practice that integrates preventative care and medical treatment in addition to cutting-edge research. Our approach creates a standard of excellence in the specialized care of women.

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INTAKE FORM

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

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 ______________________

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
6. Take an immediate left into one of the two parking lots at the Lakeview Medical Dental Building. If these two lots are full, additional parking may be found across the street.
7. 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.
6. Take an immediate left into one of the two parking lots at the Lakeview Medical Dental Building. If these two lots are full, additional parking may be found across the street.
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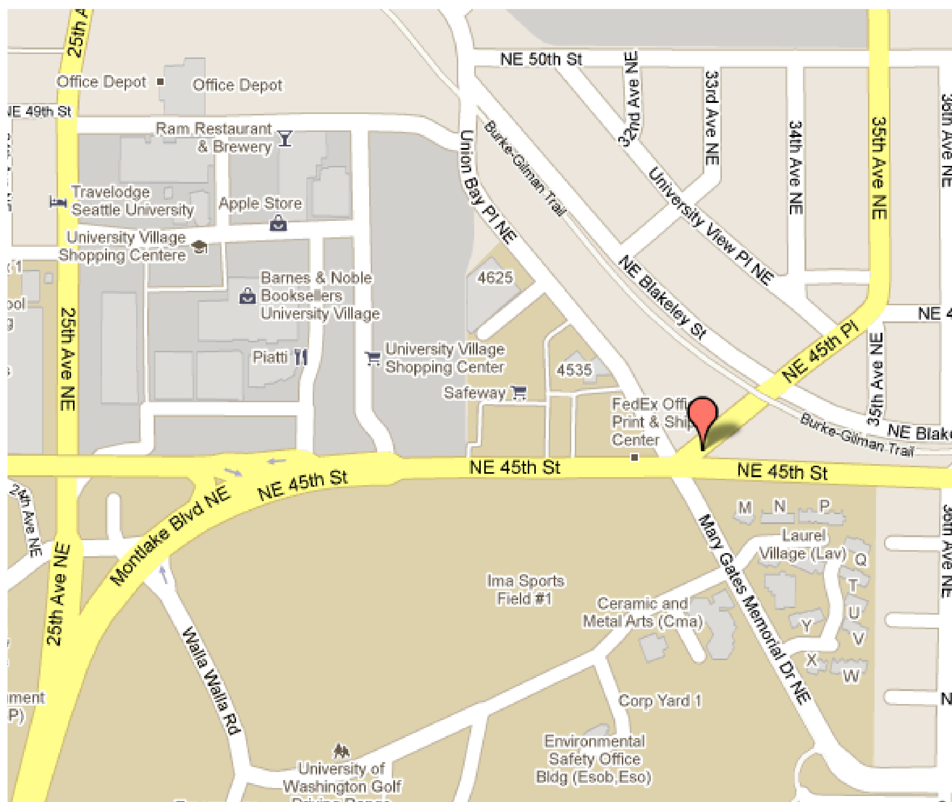
Via Seattle Metro Transit

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.



Parking

Due to some construction behind the Lakeview Medical Dental Building, the lot behind our office is no longer accessible for patients. The map below has been created to display available parking lots. These spaces are free and are reserved for Lakeview Medical Dental Building patients.