Today's date______/______/______ Date of appointment______/______/______

MEDICAL AND REPRODUCTIVE HISTORY - ENDOCRINE

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/Providence: _________________ Zip/Postal Code: ____________________ Country: _____________________

	OK to leave message?		Best # to reach you:
Home Phone Number: (______)______-___________	☐ 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)____
  - o Name of office/physician: ____
- ☐ 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):

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

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

☐ Regular periods ☐ Irregular period ☐ No periods
☐ Spotting between periods ☐ Heavy periods ☐ 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)

☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Other
☐ Syphilis ☐ Genital Warts ☐ Trichomonas _____________
☐ HIV ☐ HPV ☐ 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
☐ Birth Control Pill / Patch	
☐ Depo-Provera, Lunelle	
☐ Nuva Ring	
☐ Norplant/Implanon	
☐ Diaphragm	
☐ IUD	
☐ Condoms	
☐ Tubal Sterilization	
☐ Vasectomy	
☐ Rhythm (natural method)	
☐ 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:	Yes	No	Date	Result normal? Yes	No	If no, describe:
LH/FSH level	☐	☐	____/____/____	☐	☐	________________________________
Progesterone level(s)	☐	☐	____/____/____	☐	☐	________________________________
Endometrial Biopsy	☐	☐	____/____/____	☐	☐	________________________________
Thyroid blood test	☐	☐	____/____/____	☐	☐	________________________________
Prolactin blood test	☐	☐	____/____/____	☐	☐	________________________________
Fasting blood glucose	☐	☐	____/____/____	☐	☐	________________________________
Insulin level	☐	☐	____/____/____	☐	☐	________________________________
Testosterone level	☐	☐	____/____/____	☐	☐	________________________________

PREVIOUS TREATMENT

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

Medication	Type/Years Used and Result
☐ Birth Control Pill/Patch	
☐ Provera (depot (IM) or oral)	
☐ Lunelle	
☐ Depo-Lupron	
☐ Danazol	
☐ Clomiphene (clomid, serophene)	
☐ Gonadotropins (Pergonal, Gonal F, Follistim, Repronex, Metrodin, etc)	
☐ Estrogen (premarin, estrace, patch)	
☐ Bromocriptine or dostinex	
☐ Thyroid replacement	
☐ Dexamethasone, prednisone, or cortisone	
☐ Metformin (glucophage)	
☐ Avandia (rosiglitizone)/Actos(pioglitazone)	
☐ Spironolactone (aldactone)	
☐ 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:

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

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	☐	☐	☐	
Alcohol	☐	☐	☐	
Social drugs	☐	☐	☐	
Exercise	☐	☐	☐	

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	OTHER
		Mother	Father	Sisters	Brothers	GM	GF	GM	GF	Children	Relatives
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:____

____