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

RESEARCH PARTICIPANT REGISTRATION FORM

PATIENT: _____ DOB: ___ / ___ / ___ AGE: ____
Last Name First Name M.I.

ADDRESS: _____ CITY:_____ STATE: ____ ZIP: _____

HOME PHONE: _____ WORK: _____ MOBILE: _____

EMAIL: _____

SOCIAL SECURITY NUMBER # (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*, NAME OF SCHOOL: _____

OCCUPATION: _____ EMPLOYER: _____

CHECK ALL OF THE FOLLOWING THAT APPLY:

OKAY TO LEAVE A DETAILED MESSAGE:
- ☐ on home #
- ☐ on voicemail at work #
- ☐ on mobile #
- ☐ at a different phone #:

OKAY TO LEAVE INFORMATION WITH:
- ☐ Spouse/partner (name): _____
- ☐ Other family member (relationship & name): _____

OKAY TO LEAVE APPOINTMENT REMINDERS VIA:
- ☐ Phone Call ☐ Text Message ☐ Email

OKAY TO CONTACT YOU ABOUT UPCOMING RESEARCH STUDIES VIA:
- ☐ Phone Call ☐ Text Message ☐ Email

HOW DID YOU HEAR ABOUT US?
- ☐ Patient of our medical practice
- ☐ Previous study participant/screen
- ☐ Print Ad
- ☐ Website
- ☐ Craigslist
- ☐ Instagram
- ☐ Facebook
- ☐ Other: _____
- ☐ Friend/Family/Co-worker (Name, so we can thank them: _____

EMERGENCY CONTACT

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

PATIENT: _____ DOB: ___ / ___ / ___ AGE: ____ DATE: _____
Last Name First Name M.I.

GENDER: MALE ☐ FEMALE ☐ OTHER ☐ _____

PRIMARY CARE
Name Address Phone

PHARMACY
Name Address Phone

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 ☐				
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	Now ☐ In the past ☐				
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 ☐				

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	Y / N	
Father	Y / N	
Sibling	Y / N	
Sibling	Y / N	
Sibling	Y / N	
Other	Y / N	

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: Y / N Average amount per day: _____ Year began: _____ Year quit: _____
Alcohol use: Y / N Average number of drinks per week: _____
Current or past history of substance abuse: Y / N Year began: _____ Year quit: _____

IMMUNIZATIONS

Yearly flu shot	Y / N
Measles/Mumps/Rubella vaccine Varicella vaccine (or had chicken pox)	Y / N Y / N
If age 65 or over, pneumococcal vaccine	Y / N
Ever been tested for TB Was it positive? BCG vaccine (TB vaccine)	Y / N Y / N Y / N
Series of vaccines for HPV (Human Papilloma Virus)	Y / N All three vaccines ☐ The first one only ☐ Two vaccines ☐
Date of last tetanus shot *(recommended every 10 years)*	_____

OBSTETRIC HISTORY (PREGNANCY)

FEMALES:

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
Date of 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:_____	Now ☐ In the past ☐				
Uterine fibroids	Now ☐ In the past ☐				
Ovarian Cyst	Now ☐ In the past ☐				
Vaginal Dryness	Now ☐ In the past ☐				
Hot Flashes/ Vasomotor symptoms	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: ☐ Gonorrhea ☐ HPV ☐ Chlamydia ☐ Herpes ☐ Other:_____	Now ☐ In the past ☐				
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 _____

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MAP AND DIRECTIONS

From North or South via I-5

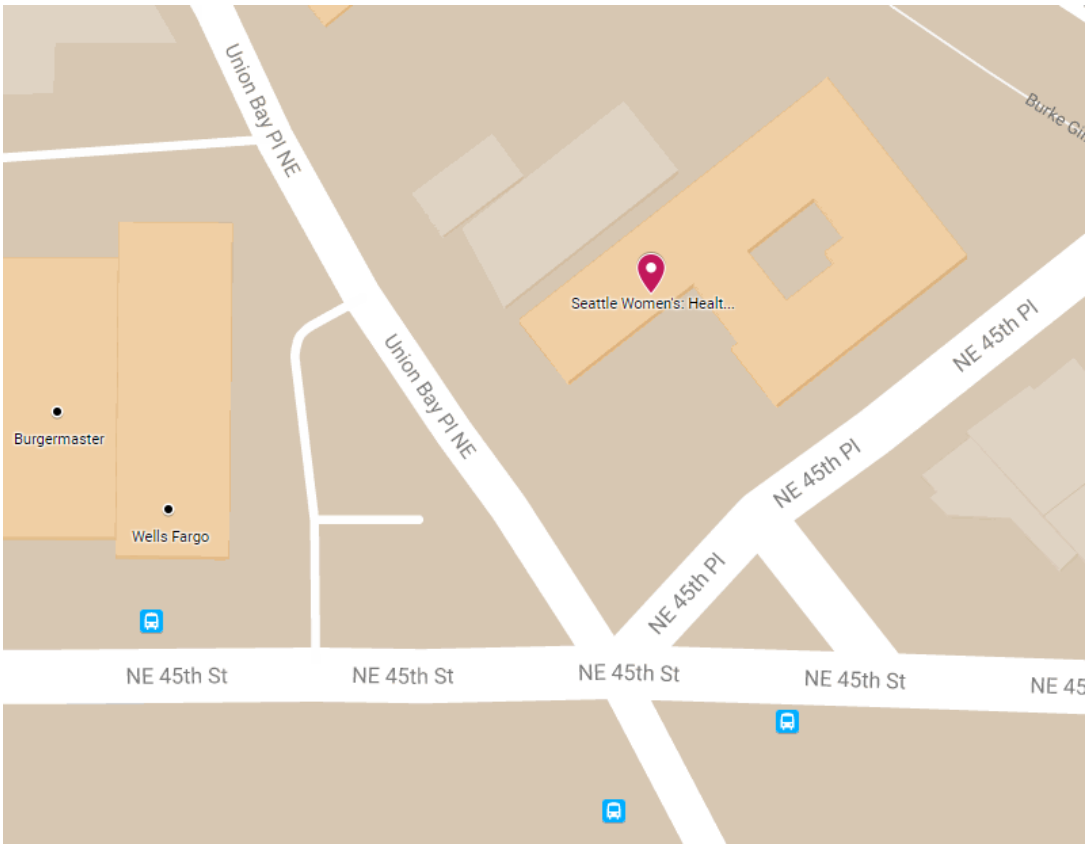
1. Take I-5 to the 45th Street exit
2. Turn East onto NE 45th Street
3. Continue on NE 45th Street past the University of Washington and down the hill
4. Turn left at the stoplight and continue on NE 45th Street past University Village to the 5-way intersection. There are two left turn lanes - choose 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. 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. 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.



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PARKING MAP

There have been recent changes to our available parking spaces. The map below has been created to display available parking lots. These spaces are free and are reserved for Lakeview Medical Dental Building patients. Parking can be found in our front lot, back lot and a parking garage. The parking garage is accessible through the back lot. There is a 2 hour maximum for these parking lots, but we will provide you with a parking pass if your appointment should run longer than 2 hours.

NOTE: **The garage closes promptly at 7:00 PM. If you do NOT move your car before 7:00 PM you will be unable to move your car until next business day