



Attention - DO NOT enter patient data on this form if the header does not contain preprinted CRISP ID number, clinical center ID, and visit number.

Participant ID: _____ pkdid

Clinical Center: _____ pccn

visit:

Women OB-GYN History Form

1. Date of visit: *dvdate*

		/			/						
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2. Age at Menarche: *mena*

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3. Age at Menopause: *menage*

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N/A
menagena

4. Pregnancy: *preg*

If visit 6, Have you ever been pregnant?

If visit 8, Have you had any pregnancies since the last visit?

0 No – Go to #5

1 Yes – Go to #4a

4a. Number of pregnancies _____ *pregnum*

Number of deliveries _____ *pregdel*

Dates of deliveries:

<i>delmt1</i> ___/___ <i>delyr1</i>	<i>delmt2</i> ___/___ <i>delyr2</i>	<i>delmt3</i> ___/___ <i>delyr3</i>
<i>delmt4</i> ___/___ <i>delyr4</i>	<i>delmt5</i> ___/___ <i>delyr5</i>	<i>delmt6</i> ___/___ <i>delyr6</i>
<i>delmt7</i> ___/___ <i>delyr7</i>	<i>delmt8</i> ___/___ <i>delyr8</i>	<i>delmt9</i> ___/___ <i>delyr9</i>
<i>delmt10</i> ___/___ <i>delyr10</i>	<i>delmt11</i> ___/___ <i>delyr11</i>	<i>delmt12</i> ___/___ <i>delyr12</i>

Number of still births _____ *pregbirth*

Number of abortions _____ *pregabort*

Number of miscarriages _____ *pregmis*

Pregnancy related complication? *pregcomp*

0 No – Go to #5

1 Yes – Check all that apply

<input type="checkbox"/> 1. Pre-eclampsia <i>pregcomp1</i>	<input type="checkbox"/> 6. Intrauterine Growth Retardation (IUGR) <i>pregcomp6</i>
<input type="checkbox"/> 2. Pregnancy-associated proteinuria <i>pregcomp2</i>	<input type="checkbox"/> 7. Prematurity <i>pregcomp7</i>
<input type="checkbox"/> 3. Pregnancy-induced hypertension <i>pregcomp3</i>	<input type="checkbox"/> 8. Gestational diabetes <i>pregcomp8</i>
<input type="checkbox"/> 4. Hypertension <i>pregcomp4</i>	<input type="checkbox"/> 9. Other, Specify: <i>pregcomp9</i>
<input type="checkbox"/> 5. Pre-term labor <i>pregcomp5</i>	_____ <i>pregcompot</i>



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5. Hormone Exposure: *hormonexp*

If visit 6, Have you ever used contraception?

If visit 8, Have you used contraception since the last visit?

0 No – Go to #5b

1 Yes – Complete section #5a

5a. Contraception:

	Start Date of Treatment	Duration of Treatment	Medicine
		# Months # Years	
<input type="checkbox"/> Oral <i>contoral</i>	<i>oralmt</i> ____/____ <i>oraltxyr</i>	____ <i>ordumt</i> ____ <i>orduyr</i>	_____ <i>oraltx</i>
<input type="checkbox"/> Injection <i>continject</i>	<i>injmt</i> ____/____ <i>injecttxyr</i>	____ <i>injdumt</i> ____ <i>injduyr</i>	_____ <i>injecttx</i>
<input type="checkbox"/> Patch <i>contpatch</i>	<i>patmt</i> ____/____ <i>patchtxyr</i>	____ <i>patdumt</i> ____ <i>patduyr</i>	_____ <i>patchtx</i>
<input type="checkbox"/> NovaRing <i>contring</i>	<i>ringmt</i> ____/____ <i>ringtxyr</i>	____ <i>ringdmt</i> ____ <i>ringdyr</i>	_____ <i>ringtx</i>
<input type="checkbox"/> Other <i>conotcont</i>	Specify _____	_____ <i>othsp</i>	

5b. Fertility Treatment: *fertiltx*

If visit 6, Have you ever had fertility treatment(s)?

If visit 8, Have you had any fertility treatment(s) since the last visit?

0 No – Go to #5c

1 Yes – Complete section #5b

Number of Treatments: _____ *fertntx*

Date of Treatment

Medicine

*fertlmt1*____/____ *fertiltxyr1*

_____ *fertiltxmed1*

*fertlmt2*____/____ *fertiltxyr2*

_____ *fertiltxmed2*

*fertlmt3*____/____ *fertiltxyr3*

_____ *fertiltxmed3*



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5c. Perimenopausal Hormone Therapy: *pmhtherapy*

If visit 6, Have you ever had hormone exposure?

If visit 8, Have you had hormone exposure since the last visit

0 NO – Go to #6

1 Yes – Complete section #5c

	Start Date of Treatment	Duration of Treatment	Medicine
		# Months # Years	
<input type="checkbox"/> Oral <i>pmhoral</i>	<i>pmormt</i> ____ / ____ <i>pmhoraltxyr</i>	____ <i>pmordmt</i> ____ <i>pmordyr</i>	_____ <i>pmhoraltx</i>
<input type="checkbox"/> Injection <i>pmhinject</i>	<i>pminjmt</i> ____ / ____ <i>pmhinjectxyr</i>	____ <i>pminjmt</i> ____ <i>pminjdyr</i>	_____ <i>pmhinjecttx</i>
<input type="checkbox"/> Patch <i>pmhpatch</i>	<i>pmpatmt</i> ____ / ____ <i>pmhpatchtxyr</i>	____ <i>pmpatmt</i> ____ <i>pmpatdyr</i>	_____ <i>pmhpatchfx</i>
<input type="checkbox"/> Other <i>pmother</i>	Specify _____ <i>pmspc</i>		

6. Gynecologic Surgery: *gynsurgery*

If visit 6, Have you ever had gynecologic surgery?

If visit 8, Have you had gynecologic surgery since the last visit?

0 No – STOP

1 Yes – Complete section #6

		Age at Surgery
0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Hysterectomy <i>hysyn</i>	_____ <i>hysynage</i>
0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Unilateral oophorectomy <i>unioopyn</i>	_____ <i>unioopynage</i>
0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Bilateral oophorectomy <i>biloopyn</i>	_____ <i>biloopynage</i>
0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Hysterectomy and oophorectomy <i>hysynoopyn</i>	_____ <i>hysynoopynage</i>
0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Tubal Ligation <i>tlyn</i>	_____ <i>tlynage</i>
0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes	Other <i>hypothe</i> Specify _____ <i>otsurgspc</i>	

CRISP Member completing this form _____
cdidnum

Date Form Completed ____ / ____ / ____
cddate

Data Entry Status: Please check to indicate that the above information has been entered

Primary Entered by: _____ Date: ____ / ____ / ____ *dedate*
deidnum

Secondary Entered by: _____ Date ____ / ____ / ____