Gynecologic Oncology New Patient Questionnaire

Date:	Name	
Marital Status: S M D W other	Date of Birth:	Age:
Home Phone:	Work Phone:	
Cell/Other phone:	Occupation:	
Emergency Contact/Phone# other than your own:		
Referring MD/address/phone/fax:		
Primary MD/address/phone/fax:		
Other MD/address/phone/fax:		

Please circle all MD's you wish to have your medical notes and test results sent to.

Reason for seeing MD today?

How long have you experienced this problem?

Have you had any of the following tests done for this problem? (check all that apply)

	Which facility?	Are the results available?*
Ultrasound or Sonogram		
CT or Cat scan		
Chest X-Ray		
Barium Enema		
Tissue Biopsy		
Laboratory Tests		
Other_____		

*Please note that all diagnostic results pertaining to your current problem must be available in order to have a complete consultation***

Past Medical History

Have you ever been hospitalized for a medical condition? Y ☐ N ☐

When and what reason?

Do you have or have you had any of the following?

High blood pressure	Y ☐ N ☐	Kidney Disease	Y ☐ N ☐
Diabetes	Y ☐ N ☐	Liver Disease	Y ☐ N ☐
Asthma	Y ☐ N ☐	Cancer	Y ☐ N ☐
Other lung disease	Y ☐ N ☐	Blood Disorder	Y ☐ N ☐
Stroke	Y ☐ N ☐	Mental/Psychologic disorder	Y ☐ N ☐
Heart disease	Y ☐ N ☐	Other_____	Y ☐ N ☐
Blood Clot	Y ☐ N ☐	Other_____	Y ☐ N ☐

If Yes, please describe:

Past Surgical History Have you ever had surgery? Y ☐ N ☐
If yes, please list procedure and dates?

_____

_____

Did you experience any complications such as:
Unexpected bleeding Y ☐ N ☐, Problems with anesthesia Y ☐ N ☐, Infection Y ☐ N ☐

Medications (Include over the counter pills or vitamins/herbals/complementary)

_____

_____

_____

Allergies: To medications _____
To food or other _____

Preventative Screening

Last Mammogram? _____ Normal or Abnormal?
Last Colonoscopy? _____ Normal or Abnormal?
Last DEXA/bone density scan? _____ Normal or Abnormal?

Gynecologic History

Age of first menstrual period _____ Last PAP smear? _____ Normal or Abnormal?
Pre-menopausal:
Date of last period _____ duration of menstrual cycles _____
Post-menopausal:
What age was your last menstruation/menopause(change of life)? _____
Any menopausal symptoms? Y ☐ N ☐ Explain _____
Are you sexually active? Y ☐ N ☐
Have you ever used/ do you use contraception? Y or N? What type? _____
Have you ever had: abnormal PAP Y ☐ N ☐ abnormal vaginal bleeding Y ☐ N ☐
uterine fibroids Y ☐ N ☐ pelvic infection or sexually transmitted disease Y ☐ N ☐

Obstetrical History How many times have you been pregnant? _____
# of miscarriages _____ # of terminations _____

Month/Year of Births:

	vaginal or c-section?	premature or full-term?
	vaginal or c-section?	premature or full-term?
	vaginal or c-section?	premature or full-term?
	vaginal or c-section?	premature or full-term?

Social History

With whom do you live? _____
How often do you exercise? _____ Are you on a special diet? _____
Do you smoke/Have you ever smoked? Y ☐ N ☐
Packs per day? _____ How many years? _____ When quit? _____
Do you drink alcohol? Y ☐ N ☐ How much/How often? _____
Have you ever used illegal drugs? Y ☐ N ☐ _____

Family History (i.e.: cancers and type, heart disease, stroke, hypertention, diabetes, etc. and age of onset)

	Age now	Or age of death	Any Illnesses
Father			
Mother			
Sister/ Brother			
Sister/ Brother			
Sister/ Brother			
Sister/ Brother			
Daughter/Son			
Daughter/Son			
Daughter/Son			
Spouse			

Do you have ANY other blood relatives with cancer(who/what type)?

_____

Review of Systems Do you have any of the following now or recently? circle all that apply

Weight loss/gain, unusual fatigue, night sweats, loss of appetite, fainting	Y☐ N☐	
Eye or lid problems, change in vision	Y☐ N☐	
Change in hearing, ringing in ears	Y☐ N☐	
Nasal congestion, nosebleeds, sore throat, cold symptoms, dental problems, hoarseness	Y☐ N☐	
Shortness of breath, cough, wheezing, coughing up blood	Y☐ N☐	
Chest pain/pressure with exertion, palpitations, swelling in legs/ankles	Y☐ N☐	
Breast lump or soreness	Y☐ N☐	
Nausea, vomiting, heartburn, diarrhea, constipation	Y☐ N☐	
Abdominal pain, bloating	Y☐ N☐	
Blood in stool, hemorrhoids	Y☐ N☐	
Difficulty urinating, pain with urination, blood in urine,	Y☐ N☐	
Increased frequency +/or waking up at night to urinate, leaking urine	Y☐ N☐	
Irregular vaginal bleeding, heavy periods	Y☐ N☐	
Unusual vaginal discharge, pain with intercourse	Y☐ N☐	
Muscle pain or weakness, joint pain, stiffness	Y☐ N☐	
Mood swings, depression, anxiety attacks	Y☐ N☐	
	Y☐ N☐	

The above information will be a part of your medical record and will be protected according to the privacy regulations under the Health Information Portability and Privacy Act (HIPPA).

Patient's signature_____ Date _____

Reviewed by _____MD / MD resident / APN / RN /student

THIS PAGE FOR OFFICE USE ONLY

Vital signs: Taken by:_____initials
Temp_____ BP_____ HR_____ RR_____ O2_____
HEIGHT_____ inches WEIGHT_____ lbs BSA_____
PAIN (0-10) _____ Location_____

HPI:

General Physical Examination
General_____
Skin_____
HEENT_____
Neck_____
Breast_____
Lungs_____
CV_____
Abdomen_____
Lymph nodes_____
Extremities_____
Musculoskeletal_____
Neurologic_____
Pelvic: External genitalia_____
Vagina_____
Cervix_____
Uterus_____
Adnexa_____
Rectum_____
PAP taken Y ☐ N ☐
Other_____

Assessment:_____

Plan:

Note IN EPIC Y ☐ N ☐ Note Dictated Y ☐ N ☐

Signature:_____Title_____Date_____
Attending MD_____