GYNECOLOGIC ONCOLOGY SPECIALISTS

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Today's Date: ________________

Reason for today's visit? ________________________
Doctor who referred you? ________________________
Do you have a primary care provider (family doctor, internist, nurse practitioner)
who is taking care of you for regular check-ups? ☐ Yes ☐ No
If yes, please provide name and contact number: ____

Patient Name: ______________________________ Date of Birth: ________________
Age____________ Height___________ Weight ______________________________
Current occupation : ____
Marital Status: ☐ Single ☐ Married ☐ Life Partner ☐ Separated ☐ Divorced ☐ Widowed
Spouse / Partner name (if applicable): ________________________________
Best contact phone numbers:
____
Email:

Gynecological History

First day of your last menstrual period: ________________
How old were you when your menses started? ________________
Menopause? ☐ Yes ☐ No
- Age of menopause (last menstrual period)? __________________________
Are you currently experiencing:
☐ Hot Flashes ☐ Vaginal Dryness ☐ Sleep Interruptions ☐ Abnormal/Irregular Periods
☐ Post-Menopausal Bleeding ☐ Other: ______________________________

Date of last Pap smear: ______________________ Result: ______________________
Abnormal Pap Smears - Have you ever had an abnormal Pap or Colposcopy? ☐ Yes ☐ No
Have you had any treatments to your cervix?
☐ No ☐ Cryosurgery ☐ Laser Surgery ☐ LEEP ☐ Conization ☐ Other: ________________
Do you experience any of the following:
Loss of urine when coughing, sneezing, or laughing? ☐ Yes ☐ No
Frequent urination? ☐ Yes ☐ No
Pain during urination? ☐ Yes ☐ No
Need to urinate with little warning? ☐ Yes ☐ No
Do you ever lose urine before reaching the toilet? ☐ Yes ☐ No

Breast History

Are you here today for a Breast issue? ☐ Yes ☐ No If "No", Skip to the next Section

Bra size ____________ Cup size __________

Do you feel a breast lump? ☐ Yes ☐ No

Do you have nipple discharge? ☐ Yes ☐ No

Do you have breast pain? ☐ Yes ☐ No

Do you have a history of breast cysts? ☐ Yes ☐ No

Do you have inverted nipples? ☐ Yes ☐ No ☐ Unsure

Do you have any breast skin changes? ☐ Yes ☐ No

Have you had cosmetic breast implants? ☐ Yes ☐ No

Last Mammogram _____________________ Where? __________________________________

Last Breast MRI _______________________ Where? __________________________________

Last Breast ultrasound __________________ Where? __________________________________

If possible, list locations and dates of any prior Breast Imaging:

____

____

Ever had a breast biopsy? ☐ Yes ☐ No Date/location: ____

Have you ever had breast cancer? ☐ Yes ☐ No Age________________

Have you ever had a partial mastectomy or lumpectomy? ☐ Yes ☐ No Which breast? ☐ L ☐ R

Have you ever had a full mastectomy? ☐ Yes ☐ No Which breast? ☐ L ☐ R

Did you have reconstruction? If yes, circle the option that applies to you:

Saline implants silicone implants DIEP flap

LAT flap TRAM flap

Have you had radiation to the breast area? ☐ Yes ☐ No Which breast? ☐ L ☐ R

Have you had chemotherapy for breast cancer? ☐ Yes ☐ No

Have you had chemotherapy for any cancer? ☐ Yes ☐ No When?________ What cancer?____________

Have you taken medication for breast cancer? ☐ Yes ☐ No When?_______________

Circle the medication: Tamoxifen Femara Aromasin Arimidex Letrozole

Other: ___________________________________

Past Operations/Hospitalizations

Please indicate the year and reason for operation/hospitalization

____

____

____

____

____

Pregnancy History

Number of Pregnancies______________ **Number of live births**____________ **Number of living children**_________

Medical History

Please list your medical problems and the date of diagnosis (for example: high blood pressure, diabetes, etc.)

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____

____

____

____

Allergies to Medications (please list medication and what type of reaction you had):

____

____

____

____

Current Medications:

(Please list all medicine and over-the-counter medicine prior to gynecological visit, including hormones, vitamins, and herbs)

Medication Name (Brand/Generic)	Dose	Frequency	Start Date	End Date	Prescribed By	Initials of Reviewer

Social History

Current and Past Alcohol Intake (drinks per week): ____________________

Do you use recreational drugs? ☐ Yes ☐ No

Have you ever received treatment for substance abuse? ☐ Yes ☐ No

Do you use Tobacco? ☐ Yes ☐ No ☐ Past use

If yes, what age did you start or how many years? ____________________

Exercise (type, frequency, duration): ____

Describe your diet: ____

Are you losing weight? ☐ Yes ☐ No

Personal Safety

Do you feel safe at home? ☐ Yes ☐ No

Have you ever been sexually, physically or emotionally abused? ☐ Yes ☐ No

Health Maintenance and Screening (if you've had and know the results):

Date and result of last mammogram: Date: __________ Result: __________

Date and result of last colonoscopy or sigmoidoscopy (50+): Date: __________ Result: __________

Date and result of last bone density test: Date: __________ Result: __________

Family History

Please mark an "X" in the appropriate box for family member pertaining to:

	Mother	Maternal Grandmother	Maternal Grandfather	Father	Paternal Grandmother	Paternal Grandfather	Sister	Brother	Child
Breast Cancer									
Ovarian Cancer									
Uterine Cancer									
Colon Cancer									
Pancreatic cancer									
Diabetes									
High Blood Pressure									
Heart Disease									
Osteoporosis									
Stomach cancer									
Melanoma									

Please list any other family history details: ____

____

Review of Biological Systems: Are you experiencing any of the following?

1. Constitutional

Fatigue ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Unintentional Weight Loss ☐ Yes ☐ No
Unintentional Weight Gain ☐ Yes ☐ No

2. Ears/Nose/Mouth/Throat

Frequent Nosebleeds ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Sore/Ulcer in the Mouth ☐ Yes ☐ No

3. Cardiovascular

Chest Pain ☐ Yes ☐ No
Calf Pain or Shortness of Breath with Walking ☐ Yes ☐ No
Palpitations ☐ Yes ☐ No
Swelling in the Feet and/or Ankles ☐ Yes ☐ No
Rapid Heart Rate ☐ Yes ☐ No

4. Respiratory

Exposure to Tuberculosis ☐ Yes ☐ No
Sudden Onset of Painful and Difficult Breathing ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No

5. Gastrointestinal

Acid Reflux/Heartburn ☐ Yes ☐ No
Bloating ☐ Yes ☐ No
Constipation ☐ Yes ☐ No
Diarrhea ☐ Yes ☐ No
Nausea/Vomiting ☐ Yes ☐ No
Change with Bowel Movements ☐ Yes ☐ No

6. Musculoskeletal

Joint Pain/Back Pain ☐ Yes ☐ No
Muscle Weakness ☐ Yes ☐ No
Joint Stiffness ☐ Yes ☐ No

7. Skin

Acne ☐ Yes ☐ No
Atypical Moles ☐ Yes ☐ No
Breast Tenderness ☐ Yes ☐ No
Breast Skin Changes/Masses ☐ Yes ☐ No
Nipple Discharge ☐ Yes ☐ No

8. Neurological

Headaches ☐ Yes ☐ No
Seizures ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Trouble Walking ☐ Yes ☐ No

9. Hematological

Easy Bruising ☐ Yes ☐ No
Cuts that do not stop bleeding ☐ Yes ☐ No
Enlarged/Swollen Lymph Nodes ☐ Yes ☐ No

10. Endocrine

Heat/Cold Intolerance ☐ Yes ☐ No
Excessive Hair Growth ☐ Yes ☐ No
Abnormal Thirst ☐ Yes ☐ No

11. Psychiatric

Anxiety ☐ Yes ☐ No
Crying Spells ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Feeling Stressed ☐ Yes ☐ No
Loss of Interest in Pleasurable Activities ☐ Yes ☐ No
Poor Concentration ☐ Yes ☐ No
Prolonged Sadness ☐ Yes ☐ No
Sleep Disturbances ☐ Yes ☐ No
Suicidal Thoughts ☐ Yes ☐ No

Date Reviewed: ______________________________ Physician Signature: ________________________________