



Division of Gynecologic Oncology

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Patient Name: _____ DOB: _____ Date: _____

Welcome to our practice. Please answer the following questions in the appropriate spaces below. Use a question mark (?) if you are unsure of an answer. Please answer all questions as completely as possible. Please complete both front and back of each page.

What is your understanding of why you are here?

Allergies:

Yes ____ No ____ Do you know of anything you are allergic to or gives you a rash?

If so, please list:

Drug/Food	Reaction
_____	_____
_____	_____
_____	_____

Medications:

Yes ____ No ____ Do you take any medications regularly? Please include prescriptions as well as over the counter medications, vitamins, and supplements.

Medications	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Yes ____ No ____ Pain or incontinence with urination
Yes ____ No ____ Constipation or Diarrhea
Yes ____ No ____ Weight gain or weight loss
Yes ____ No ____ Swelling of hands or feet
Yes ____ No ____ Problems with eyesight or hearing
Yes ____ No ____ Pain _____ Location _____: Please rate on a scale from 1-10 with 10 being the worst pain you have experienced: _____



Screening:

Yes___ No___ Have you had a mammogram? When? _____ Results? _____
 Yes___ No___ Have you had a colonoscopy? When? _____ Results? _____
 Yes___ No___ Have you had a pap smear? When? _____ Results? _____

Surgical History:

Yes___ No___ Have you had any surgeries or hospitalizations? Please list with approximate year.

Gynecologic History:

Yes___ No___ Have you ever been pregnant? Number of pregnancies? _____ Number of births? _____
 Yes___ No___ Are you currently sexually active? Method of birth control? _____
 Yes___ No___ Have you used birth control pills or hormones? For how long? _____
 Yes___ No___ Have you gone through menopause? Date of last menstrual period? _____

Social History:

Yes___ No___ Do you drink alcohol? How often? _____
 Yes___ No___ Do you smoke? Daily _____ Occasionally _____ Former smoker _____
 Yes___ No___ Do you use recreational drugs? _____
 Marital Status: Married _____ Single _____ Widowed _____ Divorced _____ Life Partner _____
 Occupation: _____

Medical/ Family History: Please check “Self” if you have had one of the following problems, check “Family” and indicate which member of your family has/had this condition.

Condition:	None	Self	Family (please indicate relation of relative)
Arthritis			
Alzheimer’s disease			
Asthma			
Blood clots			
Diabetes			
Hypertension			
Heart disease			
HIV			
Hepatitis			
Kidney disease			
Stroke			
Other			

Cancer History:

Yes ___ No ___ Do you have a history of cancer?

If yes, please complete the table below for your past cancer, radiation treatment, or chemotherapy that you may have had.

Past cancer type	Age of first Diagnosis	Did you receive chemotherapy?			Did you have surgery?			Did you have radiation therapy?			Did you have another treatment type?		
		Yes	Age	No	Yes	Age	No	Yes	Age	No	Yes (List Type)	Age	No

Yes ___ No ___ Do you have any family history of cancer?

If yes please complete the table below for family history of cancer. Please provide as much detail as you can about any additional relatives who have had cancer on your paternal (father's side of the family) and maternal (mother's side of the family) relatives. Remember to include those who are no longer living.

	Been diagnosed with cancer?		If YES:	
	Yes	No	Type of Cancer	Age of onset
Mother				
Father				
Sons				
Daughters				
Brothers				
Sisters				
PATERNAL (Father's side)				
Cousins				
Grandsons				
Granddaughters				
Grandfather				
Grandmother				
Uncles				
Aunts				
Half-brothers				
Half-sisters				
Other relatives				
MATERNAL (Mother's side)				
Cousins				
Grandsons				
Granddaughters				
Grandfather				
Grandmother				
Uncles				
Aunts				
Half-brothers				
Half-sisters				
Other relatives				

Yes____ No____ Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?

Advanced Directives:

Yes____ No____ Have you completed a Health care proxy or Advanced directive?

Yes____ No____ If not would you like information regarding appointing a Health care proxy?

Please list other healthcare providers who should receive information regarding your care:

To the best of my knowledge, the information provided on this form is accurate and complete.

Signature of Patient or Representative: _____ *Date:* _____

Date reviewed: _____ *by:* _____

**AMBULATORY CARE INVOLVEMENT IN CARE
DISCUSSION FORM**
(Reference HIPAA Policy 0P23.2)

Patient Name: _____ Date: _____

Gynecologic Oncology may discuss protected health information, including lab/test results with the following people:

Name	Relationship	Phone Number

NEXT OF KIN INFORMATION

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Number: _____

COMMUNICATION REQUESTS:

Phone me using the following (#) _____

Y N

____ May phone at work (#) _____

Employer Name: _____

____ May leave messages on answering machine

____ May send message via MyChart

This will remain in effect until notified differently by the patient.

Patient Signature _____ Date: _____