GYNECOLOGIC ONCOLOGY

INTAKE FORM

Name_______________________________
____

Date of Birth ____________ Today's Date __________ Email Address:
________________________________ Referring Physician Name & Address
____ ______________

Primary Care Physician (if different)
____

What is the reason for your visit today? Is this a routine visit? Yes __ No __
____
____
_______________________________ ____

Describe the problem
____
_______________ ____
____

When did it start? ____________________ What does it feel like/what are the symptoms?
____
____
____

How severe are the symptoms? (1-10) ____________ Where are they located?
______________________ What makes it better or worse?
____ Have you been taking medications for this problem? __________

Have there been previous episodes? __________

Did you seek previous medical care of this problem? __________

Do you have any allergies to medications or other substances? Yes __ No __

If yes, please list allergies and reactions (rash, hives, throat swelling, anaphylaxis)

____

____

Please list **ALL** of your current medications below (use back of page if you need more room):

MEDICATION NAME	DOSAGE	WHEN DO YOU TAKE IT?	APPROXIMATE START DATE

OB/GYN HISTORY:

Number of pregnancies ______ Live births ____ Vaginal Deliveries ____ Cesarean Sections ____ Miscarriages ___ Tubal Pregnancies ____ Terminations ___ Living Children _____

When was your last menstrual period? ______ Age of first period __________

How frequently do you have your period? _________ If irregular, describe frequency ______

Is your flow heavy? _________ How many days do you bleed? _____ Do you stain/bleed between regular periods? ______ Do you have pain with periods? ______

If so, describe: __________________________

If your periods have stopped do you have any symptoms associated with menopause? Yes ___ No ___

If yes, describe ____

____

Are you currently sexually active? Yes ___ No ___

Do you have any problems associated with sexual relations? Yes ___ No __

If yes, Describe:

____

When was your last PAP Smear? ________________ Have you ever had an abnormal PAP? Yes __ No __ If yes, When? ___________

If you were told you had HPV describe how you were treated: _____________________

____

Have you ever been treated for for a sexually transmitted disease?

If yes, explain:____

Have you ever been tested for HIV? Yes ___ No ___ When? ___________

MEDICAL HISTORY:

Have you ever had (been diagnosed or treated for) any of the following (if yes, describe)

CONDITION	YES	NO	DESCRIBE
HEART DISORDER			
STOMACH/INTESTINAL DISORDER			
SKIN DISORDER			
CLOTTING DISORDER			
EYE DISORDER			
PSYCHIATRIC DISORDER			
URINARY/KIDNEY DISORDER			
LIVER DISORDER/ HEPATITIS			
ORTHOPEDIC DISORDER			
CHOLESTEROL DISORDER			
NEUROLOGIC DISORDER			
DIABETES			
HIGH BLOOD PRESSURE			
ARTHRITIS			
FIBROIDS			
ENDOMETRIOSIS			
CANCER			
THYROID DISORDER			
LUNG DISORDER			

OTHER SURGICAL HISTORY:

List any surgeries you have had and the approximate date:

Appendectomy __________________ Laparoscopies ____________________________

Gallbladder _____________________ Abdominal Surgeries ______________________

Tubal Ligation ___________________ Hysterectomy ___________________________

Breast Surgeries __________________ Ovaries Removed Yes ___ No __

Others: ____

Have you had a blood transfusion? Yes __ No __ If yes, when? ________________

HEALTH MAINTENANCE/DIAGNOSTIC HISTORY :

Last Mammogram ___________ Normal __ Abnormal __

Last Bone Density ____________ Normal __ Abnormal __

Last Cholesterol ______________ Normal __ Abnormal __

Last Colonoscopy _____________ Normal __ Abnormal __

FAMILY HISTORY:

Please indicate any major conditions/illnesses that your family members have had Condition & Description Living If deceased, what age?

Mother ________________________ _______ ____________________

Father ________________________ _______ ____________________

Sibling ________________________ _______ ____________________

CONDITION	YES	NO	WHICH RELATIVE
Breast cancer			
Colon cancer			
Uterine cancer			
Ovarian cancer			
Other cancer			

SOCIAL HISTORY:

Occupation: ___________________________ Who do you live with at home? _______________________ Marital Status: _____________________________________

Do you exercise regularly? Yes __ No __

Do you have a healthcare proxy? Yes __ No __

Who can be contacted with or given your health information?

NAME	RELATIONSHIP	CONTACT NUMBER

Tobacco:

Currently? Yes __ No __ Previously? Yes __ No __ Yrs Smoked ____ Packs/Day ____

Are/Were you exposed to 2nd hand smoke at home or work? Yes __ No __

If yes, Explain: ____

Other substances:

Alcohol? Yes __ No __ Recreational drugs? Yes __ No __

Describe Use ____

REVIEW OF SYSTEMS:

		YES	NO		YES	NO
General	Fevers			Chills		
	Sweats			Weight loss		
	Feeling tired			Feeling sick		
	Appetite loss			NONE OF THE ABOVE		
Eyes	Double vision			Blurring		
	Discharge			Pain		
	Light sensitivity			NONE OF THE ABOVE		
Ear/Nose Throat	Ringing in ears			Nosebleeds		
	Decreased hearing			Hoarseness		
	Earache			NONE OF THE ABOVE		
Heart	Shortness of breath			Swollen feet		
	Racing heart			Near fainting		
	Chest pain			Weight gain		
	Lightheadedness			NONE OF THE ABOVE		
Lungs	Coughing up blood			Phlegm		
	Wheezing			Shortness of breath		
				NONE OF THE ABOVE		
Gastro Intestinal	Loss of appetite			Nausea		
	Diarrhea			Vomiting		
	Constipation			Black stool		
	Blood in stool			Hemorrhoids		
	Change in bowel habits			Bloating		
	Gas			Abdominal pain		
				NONE OF THE ABOVE		
Genito Urinary	Frequent urination			Blood in urine		
	CONDITION	**YES**	**NO**	**CONDITION**	**YES**	**NO**
	Night time urination			Back pain		
	Painful urination			Pelvic pain		
	Abnormal vaginal bleeding			Urinary urgency		
				NONE OF THE ABOVE		
Musculo Skeletal	Joint pain			Stiffness		
	Arthritis			Muscle aches		
	Muscle weakness			NONE OF THE ABOVE		
Skin	Rash			Itching		
	Suspicious lesion			Nail changes		
	Hair changes			Color change		
	Open wounds			NONE OF THE ABOVE		
Neuro	Headaches			Poor balance		
	Numbness			Tingling		
	Seizures			Tremors		
	Falling down			Vertigo		

	Excessive sleepiness			Forgetfulness		
				NONE OF THE ABOVE		
Psych	Thoughts of suicide			Depression		
	Thoughts of violence			Anxiety		
	Frightening sounds or visions			NONE OF THE ABOVE		
Endocrine	Heat intolerance			Thirst		
	Weight change			NONE OF THE ABOVE		
Heme Lymph	Bleeding			Fevers		
	Easy bruising			NONE OF THE ABOVE		

Thank you for taking the time to complete this questionnaire!