# Gynecologic Oncology
# New Patient History Form

Filling out this form helps your physician understand your illness. Please answer the questions as best you can. Don't worry about spelling or exact dates. If you are uncomfortable writing something, please make a note and review it with your physician.

## Personal history

Name: ____________________

Date of birth: _____/_____/_____ Age: __________ Today's date: _____/_____/_____

Home phone: __________ Work phone: __________ Mobile phone: __________

Address: __________ City: __________ State/ZIP: __________

Emergency contact: __________ Relationship to you: __________

Home phone: __________ Work phone: __________ Mobile phone: __________

Primary doctor: __________ Address: __________

Referred by: __________ Address: __________

Other doctors you see regularly: __________ Address: __________

What is the reason for your visit today? ____________________

____________________

**Allergies:** Are you allergic to latex? ❑ Yes ❑ No **List allergies to medications, food and other items:**

____________________

____________________

____________________

| **Current medications** (Name of medication) | **Dose** (Size in gm/mg/tsp, etc.) | **Times per day** (How often, a.m., p.m., etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Preferred pharmacy:** __________ **Phone:** __________

| **Current vitamins/herbal supplements** (Name) | **Dose** (Size in gm/mg/tsp, etc.) | **Times per day** (How often, a.m., p.m., etc.) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Patient's name:** ______________________________

| **Past medical, surgical, trauma history** (Mark all that apply) | | | | | |
|---|---|---|---|---|---|
| Arthritis | | Depression/anxiety | | Pacemaker | |
| Asthma/COPD | | Diabetes | | Seizure disorder | |
| Autoimmune disease | | Frequent headaches | | Stroke | |
| Blood clots | | Heart attack | | Thyroid disease | |
| Cancer – type: ____________________ | | Hepatitis | | Transplant – type: __________________ | |
| Chest pain/discomfort | | High blood pressure | | | |
| Congestive heart failure | | Irregular heartbeat | | | |

| **Surgery history** | **Date** |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| **Family history** (List the approximate age at the time of diagnosis for those that apply) | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Mother | Father | Sibling | Sibling | Sibling | Children | Other (describe) |
| Alcoholism/drug addiction | | | | | | | |
| Alzheimer's disease/dementia | | | | | | | |
| Bleeding disorder | | | | | | | |
| Cancer: | | | | | | | |
| Breast | | | | | | | |
| Ovarian/fallopian tube | | | | | | | |
| Colon | | | | | | | |
| Pancreatic | | | | | | | |
| Uterine/endometrial | | | | | | | |
| Lung | | | | | | | |
| Cervical | | | | | | | |
| Prostate | | | | | | | |
| Other: ___________________ | | | | | | | |
| Diabetes | | | | | | | |
| Epilepsy/seizure disorder | | | | | | | |
| Heart attack | | | | | | | |
| Heart disease | | | | | | | |
| High blood pressure | | | | | | | |
| Kidney disease | | | | | | | |
| Liver disease | | | | | | | |
| Migraine headaches | | | | | | | |
| Sickle cell anemia | | | | | | | |
| Stroke | | | | | | | |
| Tuberculosis | | | | | | | |

**Patient's name:** ____________________

List immunizations you have received and dates:

____________________

____________________

____________________

Which childhood illnesses have you had: ❑ Rheumatic fever ❑ Mononucleosis ❑ Hepatitis ❑ Chickenpox ❑ Mumps ❑ Measles ❑ German measles ❑ Meningitis ❑ Tuberculosis

## Social history

Where were you born? ____________________

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Living arrangement: ❑ Alone ❑ Family ❑ Roommate ❑ Significant other

Companion's health: ❑ Fair ❑ Good ❑ Excellent

If you live alone, can someone assist you with your care after surgery? ❑ Yes ❑ No

Do you have difficulty with: ❑ Stairs ❑ Moving inside home ❑ Getting to the bathroom

Location of home: ❑ City ❑ Suburbs ❑ Rural/country ❑ No permanent residence

Do you have difficulty getting transportation to medical appointments? ❑ Yes ❑ No

Traveled outside of the U.S. in the past 5 years? ❑ Yes ❑ No If so, where: ____________________

Occupation: ____________________ Retired: ❑ Yes ❑ No If so, when: ____________________

Spouse's occupation: ____________________ Retired: ❑ Yes ❑ No If so, when: ____________________

Have you worked with harmful materials? ❑ Yes ❑ No If so, describe: ____________________

Do you smoke cigarettes? ❑ Yes ❑ No If yes, # years: ____________________ # packs per day: ____________________

Did you ever smoke? ❑ Yes ❑ No If yes, when did you quit? ____________________

Do you drink alcohol? ❑ Yes ❑ No If yes, # drinks per week: ____________________

Have you ever had a problem with alcohol? ❑ Yes ❑ No Comments: ____________________

Do you use recreational drugs? ❑ Yes ❑ No If yes, what? ____________________

Do you have a special diet? ❑ Yes ❑ No If yes, why? ____________________

What was your weight last year: __________Now: __________ If a difference, why? ____________________

____________________

**Patient's name:** ______________________________

**Health screening history** (Please list date of last exam)

Colonoscopy: ____________________ Normal: ❑ Yes ❑ No

Rectal exam: ____________________ Normal: ❑ Yes ❑ No

Fecal occult blood test: ____________ Normal: ❑ Yes ❑ No

Mammogram: ____________________ Normal: ❑ Yes ❑ No

Pap smear: ____________________ Normal: ❑ Yes ❑ No

**Review of systems** (Mark any symptoms that you currently are experiencing)

| Head | | Eyes | | Ears | | Nose | |
|---|---|---|---|---|---|---|---|
| Frequent headaches | | Recent change in vision | | Loss of hearing | | Frequent/persistent nosebleeds | |
| Severe headaches | | Detached retina | | Ringing in ears | | Hay fever | |
| Light-headedness | | Temporary vision loss | | Ear discharge | | Sinusitis | |
| Dizziness | | Wear corrective lenses | | Ear pain | | Discharge from nose | |
| Loss of consciousness | | Double/blurred vision | | | | | |

| Neck/throat | | Respiratory | | Heart | | Digestive | |
|---|---|---|---|---|---|---|---|
| Persistent hoarseness | | Persistent cough | | Heart murmur | | Gallbladder stones/attack | |
| Difficulty swallowing | | Cough with sputum | | Irregular heartbeat | | Jaundice or hepatitis | |
| Large thyroid/goiter | | Coughing up blood | | Ankles/feet swelling | | Diverticulitis | |
| Overactive thyroid | | Short of breath | | Shortness of breath walking | | Vomiting blood | |
| Underactive thyroid | | Exposure to TB | | Shortness of breath at night | | Recent change in appetite | |
| Enlarged lymph glands | | | | Chest pain during exercise | | Recent change in bowels | |
| Change in voice quality | | | | Chest tightness | | Dark black/"tarry" stools | |
| | | | | | | Red blood in stools | |
| | | | | | | Cramping/abdominal pain | |
| | | | | | | Colitis/enteritis | |
| | | | | | | Hemorrhoids | |

| Genitourinary | | Skin | | Breasts | | Neurological | |
|---|---|---|---|---|---|---|---|
| Kidney stones/colic | | Skin disorders | | Lumps/nodules | | Stroke/weakness of limbs | |
| Blood in urine | | Changing moles | | Changes in skin | | Seizures | |
| Urine/kidney infection | | Changing skin spots | | Discharge from nipple | | Epilepsy | |
| Protein/albumin in urine | | Persistent itching | | | | Loss of sensation in limbs | |
| Failing kidneys | | Persistent skin pain | | | | Loss of sensation in body | |
| Damaged kidneys | | Recent change in skin | | | | | |
| History of dialysis | | Recent change in hair | | | | | |
| Kidney transplant | | Easy bruising | | | | | |

| Emotional | | Miscellaneous | |
|---|---|---|---|
| Bipolar illness | | Bleeding from dental treatments | |
| Sleeping problems | | Increased or excessive thirst | |
| Receiving psychiatric care | | Frequently too hot or cold | |
| Excessive worrying | | Other problems (list below): | |
| Fears/phobias | | | |
| Crying spells | | | |
| Feelings of hopelessness | | | |

**Patient's name:** ________________________________

## Gynecologic history

Age at first menstruation: ______________ Age at last menstruation: ______________ Age at first pregnancy: ______________

Total number of pregnancies: ___________ Full-term births: ____________________ Premature births: ________________

Number of children born: ______________ Spontaneous miscarriages: ____________ Elective abortions: ________________

Could you be pregnant now? ❏ Yes ❏ No

Venereal diseases (VD): ❏ Yes ❏ No Details: ____________________________________________

Sexual problems: ❏ Yes ❏ No Details: ____________________________________________

Fertility treatments: ❏ Yes ❏ No Details: ____________________________________________

Hormones used: ❏ Yes ❏ No Details: ____________________________________________

Are your menstrual periods regular? ❏ Yes ❏ No Date of last menstruation: ______________________________

Number of days period lasts: ________________ Number of days between start of one period to start of next: ________________

Menstrual flow: ❏ Heavy ❏ Medium ❏ Light What do you use? ❏ Pads ❏ Tampons

Method of contraception: ❏ Oral ❏ Condom ❏ Diaphragm ❏ Natural family planning ❏ Depo-Provera ❏ Partner sterilized

❏ IUD ❏ Implant ❏ Spermicide ❏ Rhythm birth control ❏ Tubal ligation ❏ None

Describe any complications during pregnancy or delivery:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________