Welcome to Capital Health Surgical Group – Gynecologic Oncology

Name: _____ Date: _____

Referred by: _____

Primary Care Provider: (*name/address/phone*) _____

_____

Your Age: _____

Reason for today's visit: _____

How long have you experienced this problem? _____

Have you had any of the following tests in the past month? (Check all that apply and list dates)

□Ultrasound _____ □Chest X-Ray _____

□CT Scan _____ □MRI _____

Other (specify) _____

Do you have any allergies to medication? Y / N If yes, please list:

_____

Food: Y/ N (please specify) _____ IV contrast Y/N Latex Y/ N

Are you on any Medications and/or supplements (OTC): (list any additional on back of page)

Name of Medication	Dose of Medication	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle if you take any of the following on a regular basis:

Vitamin E Fish Oil/Omega-3 Ginseng Gingko biloba Green Tea

Have you had a flu shot in the last 6 months? Y / N

Pneumonia Vaccine: Y / N Shingles Vaccine: Y / N

Do you have any of the following medical problems?

◯ High Blood Pressure ◯ Diabetes ◯ Asthma ◯ Stroke

◯ Thyroid problems ◯ Heart Disease ◯ Emphysema ◯ Kidney disease

◯Cancer (*please specify*): _____

*Othe*r: _____

Have you ever been hospitalized for a medical condition? Y / N (*please specify*):

_____

Have you ever had Chemotherapy? Y / N When was your last cycle? _____

Have you ever had radiation? Y / N When was your last treatment? _____

SURGICAL HISTORY:

Have you ever undergone surgery? Y / N

If yes, please list the procedures and dates of surgery:

_____

_____

Appendectomy: *open or laparoscopic* Colectomy: *open or laparoscopic*

Tubal ligation: *open or laparoscopic* Gall bladder: *open or laparoscopic*

Hysterectomy: *open or laparoscopic* Other abdominal surgery: *open or laparoscopic*

Bowel resection: *open or laparoscopic* *specify:* _____

C-Section: Y / N Mastectomy: Y / N

Other:

_____

_____

GYNECOLOGY HISTORY:

First day of last menstrual period: _____ If menopausal, at what age _____

How often do you get your period? _____ How many days does it last? _____

How old were you when you got your first period? _____

Health Maintenance:

When was your last Mammogram? (mo/yr)_____ Pap Smear (mo/yr) _____

Colonoscopy (mo/yr) _____ Bone Density Test (mo/yr) _____

Have you had the HPV vaccine (Gardasil) Y / N

Are you currently sexually active? Y / N Any recent change in sexual function? Y / N

Any history of a sexually transmitted infection (*please circle*) :

Gonorrhea, Chlamydia, Trichomoniasis, HPV, HIV, Syphilis, or Herpes

What form of birth control do you use? _____

What have you previously used?

◯Birth control Pill ◯IUD ◯Tubal Ligation ◯Diaphragm ◯Condoms

Other: _____

If postmenopausal, have you ever used hormone replacement therapy (HRT)? Y / N

Have you ever been pregnant? yes_____ no_____ How many times total?: _____

Number of full term births (after 37 weeks)_____ Premature (less than 37 weeks) _____

Number of miscarriages _____Number of terminations (abortions) _____

Number of ectopic pregnancies _____ Largest vaginal delivery: _____lbs

Have you had a Cesarean delivery _____ How many: _____

Did you breastfeed? Y / N

FAMILY HISTORY:

Cancers, Heart Disease, Hypertension, Diabetes, *etc*.

In particular, any family members with breast, colon, uterine, ovarian, pancreatic, or prostate cancers?

Mother _____ Father _____

MGM _____ PGM _____

MGF _____ PGF _____

Maternal aunt(s) _____ Paternal Aunts _____

Maternal Uncle(s) _____ Paternal Uncle(s)_____

Sister(s) _____ Brother(s) _____

Children _____

SOCIAL HISTORY:

Do you have any history of depression? Y / N

Do you feel safe at home? Y / N

Have you ever been a victim of sexual abuse? Y / N

Can you hear and see well? Y / N

Do you smoke tobacco currently? Y / N

Have you ever smoked? Y / N When did you stop smoking? _____

How many PACKS of cigarettes/ day ? _____ For how many years? _____

Do you drink alcohol? Y / N

If yes: Do you drink more than 3 drinks per occasion? Y / N

Do you drink more than 7 drinks per week? Y / N

How many drinks does it take to make you feel high? _____

Have people annoyed you by criticizing your drinking? Y / N

Have you ever felt you ought to cut down on your drinking? Y / N

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Y / N

Do you have an advance directive (living will)? Y / N

What is/was your occupation? _____ Are you retired? Y / N

What is your marital status? Single Married Divorced Widow(er) Domestic Partner

Who do you live with? _____

Do you exercise? Y / N

Do you follow a regular diet? Y / N If no, what kind? (ie: diabetic, low salt) _____

What is your sexual orientation? Heterosexual Homosexual Bisexual

Do you have sex with men, women or both? _____

Have you ever had a blood transfusion? Y / N

Would you accept a blood transfusion in case of emergency? Y / N

Review of Health Systems:

Please indicate if you have experienced any of the following IN THE PAST 6 MONTHS:

General:	□ unintentional weight gain/loss	□fever	□ feeling poorly
Skin:	□ skin lesions	□skin wound	□itching
Eyes:	□ vision changes	□ eye pain	
ENT:	□ hoarseness	□ loss of hearing	□ nose bleeds
Dental:	□ cavities	□other _____	
Heart:	□ chest pain □palpitations	□ leg swelling	□unable to lie flat

Lungs:	□ shortness of breath at rest	□shortness of breath with activity	
	□cough	□asthma	□emphysema
GI:	□ abdominal pain	□ constipation	□ diarrhea
	□ nausea	□ vomiting	□ blood in stool
Bladder:	□ leaking urine	□ painful urination	□frequent urinary infections
	□kidney stones		
GYN:	□ painful periods	□ pelvic pain	□ vaginal discharge
	□painful intercourse		
Neuro:	□confusion	□dizziness	□weakness
	□memory loss	□headaches	
	□difficulty with balance, hearing, smell, sight, taste or touch		
Psychiatric:	□anxiety	□depression	□suicidal
	□sleep disturbance		
Endocrine:	□hot flashes	□hair loss	
Heme:	□easy bleeding	□easy bruising	□swollen glands

Please list anything else you would like us to know to provide you with the best care possible:

For office staff only:

Temp:_____ Wt: _____ Ht: _____ HR: _____ RR: _____ BP: _____

Reviewed by: _____ Date: _____