Gyn Oncology New Patient Questionnaire

Today's date: _____
Name: _____
Primary Care Doctor: _____
Referring Doctor: _____
Preferred Pharmacy: _____

OB/GYN History
Age of first period: _____
Age of last period: _____
Date of last menstrual period: _____
Are your periods REGULAR/IRREGULAR (Circle one)
Number of pregnancies: _____
Number of live birth: _____
Number of vaginal deliveries_____ Number of C –sections____ Number of miscarriages/abortions____

Have you ever used:
1. Oral contraceptive pills YES/NO If YES, Duration_____
2. Hormone replacement therapy YES/NO If YES, Duration_____
3. IUD YES/NO If YES, Duration_____

Have you ever had an abnormal pap test?
YES /NO

Date of last Pap test: _____

Health Care Maintenance
Date of last colonoscopy: _____
Date of last mammogram: _____
Date of last DEXA scan: _____

Family History
Do you have any family members with the cancers below?

Cancer	Relation	Age of diagnosis (if known)
Breast	_____	_____
Ovarian	_____	_____
Colon	_____	_____
Uterine	_____	_____
Prostate	_____	_____
Stomach	_____	_____
Pancreatic	_____	_____
Other	_____	_____ _

Social History

1. Do you smoke cigarettes? YES/NO If YES, how many per day_____ How long?
2. Do you drink alcohol? YES/NO If YES, how many per day_____ How long?
3. Do you use marijuana/cocaine/heroin/other drugs? *Circle any that apply*
4. Do you feel safe at home YES/NO

Medications

	Name	Dose	How often?
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

Medical History

Do you have any of the conditions listed below? Please check if any:

Hypertension	Depression
Diabetes	Anxiety
High Cholesterol	Previous blood transfusions
COPD (Emphysema/bronchitis)	Thyroid disease
Kidney disease	Asthma
Heart disease	Other:
Previous stroke	
Liver disease/Cirrhosis	

Surgical History

Please list any surgeries that you have had in the past

	Type	Date
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Review of Systems Check any that apply:

Vaginal bleeding	Constipation	Shortness of breath	Headaches	Weight loss
Pelvic pain	Diarrhea	Chest pains	Blurred vision	Weight gain
Leakage of urine	Abdominal pain	Palpitations	Weakness	Fever
Frequent urination	Blood in stools	Leg swelling	Dizziness	Joint pains
Burning with urination	Bloating	Cough	Depression	Loss of appetite
Nausea	Vomiting	Difficulty lying flat	Insomnia	