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 provider 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:___________