NORTHSIDE HOSPITAL

University Gynecologic Oncology

Patient Name: _____ Date of Birth:_____ Today's Date:_____

In order to give you the best medical care, it is necessary to be thorough and complete. Your entire medical history and present complaint will be reviewed with you. You will also have a complete physical examination and whatever tests and x-rays may be indicated. We would like you to fill out the following questionnaire completely and accurately. You will have an opportunity to discuss in detail any part of this history and any medical problems that you may have. You will also be able to ask any questions that may be troubling you.

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.

1. **MAIN REASON FOR VISIT** _____

_____

2. Height: _____ Weight: _____ Average Weight: _____

3. **Allergies**

Medication/Food/Other that causes allergy	Type of reaction (hives, swelling, etc.)?

4. **Current Medications** - please list all current medications you are taking, including but not limited to: blood pressure medicine, heart medicine, diuretic (water) pill, diabetes medicine, thyroid medicine, pain medicine, nerve pill/antidepressants, asthma medicine, hormones, herbal supplements, vitamins, etc.

Name of Medication	Dose of Medication	How often you take medication

Do you take blood thinners? ☐ Y ☐ N If yes, name and dose: _____

Current Pharmacy Name and Number: Name_____ Number _____

5. **Family History** - please indicate any relatives with a history of cancer or other medical problems.

Patient Name_____ Age _____

MEDICAL HISTORY FORM

If your relative had (has) cancer, please indicate **at what age** he/she was diagnosed.

Relative	Alive (A) or Deceased (D)?	List any history of **cancer** and type	Other medical problems (Stroke, Diabetes, Heart Attack, High Blood Pressure, Tuberculosis}
Mother			
Father			
Sister(s)			
Brother(s)			
Children			
Maternal Aunt(s) / Uncle(s)			
Maternal Grandmother(s) / Grandfather(s)			
Paternal Aunt(s) / Uncle(s)			
Paternal Grandmother(s) / Grandfather(s)			
Maternal Cousins			
Paternal Cousins			

Other - (in particular relatives with **cancer** of the ovary, breast, cervix, uterus, or colon): _____

_____

6. **Patient's Gynecologic/Obstetrics History**

How many pregnancies have you had? _____ Number of live births per vagina? _____ C-section? _____

Number of miscarriages? _____ Number of abortions? _____ Number of tubal pregnancies? _____

Age at first period: _____ Date of last menstrual period: _____

If not menstruating, stopped at age: _____

Due to menopause? ☐ Y ☐ N

Due to Hysterectomy? ☐ Y ☐ N If yes, reason for hysterectomy: _____

Are your periods (circle one): Regular / Somewhat irregular / Very irregular

The interval between the first day of one period to the first day of next period is about _____ days.

Menstrual flow usually lasts a total of _____ days.

Menstrual flow is usually (circle one): Scant / Moderate/ Heavy / Excessive with clots

Please check (✓) Yes or No for each question:	YES	NO
Have you had any bleeding or spotting outside of your normal period?		
If you have gone though menopause - have you had any bleeding or spotting after going through menopause?		
Have you missed any periods without being pregnant?		
Are your periods usually painful?		
Do you have any abdominal/pelvic pain unrelated to menstruation?		
Do you have any bleeding or spotting following intercourse?		

Patient Name_____ Age _____

Please check (✓) Yes or No for each question:	YES	NO
Do you ever have pain with sexual intercourse?		
Do you have any vaginal irritation, discharge, or dryness?		
Do you have any itching, irritation, sores, or lumps around your vulva or vagina?		
Do you have any loss of urine when you cough or sneeze?		
Do you frequently have a sudden urgent need to urinate?		
Do you have night urination, dribbling or urine, or bed wetting?		
Have you ever had a protrusion or bulging sensation from your vagina?		

Date of last pap smear: _____ Doctor:_____

Was your last pap smear normal? ☐ Y ☐ N Have you ever had an abnormal pap smear? ☐ Y ☐ N

If yes, when was your abnormal pap smear (year): _____ Doctor: _____

Current contraception (circle all that apply):

Birth control pills / Diaphragm / IUD / Condoms / Tubal Ligation or Implant / None

Other contraception: _____ Are you currently sexually active? ☐ Y ☐ N

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

History of Herpes: ☐ Y ☐ N If yes, date of last outbreak: _____

History of Sexually Transmitted Infection: ☐ Y ☐ N If yes, year of diagnosis: _____

If yes, type of STD/ infection: _____

7. **Patient's Medical History** - please check (✓) any /all medical problems you may have and list the **year you were diagnosed** next to each problem:

☐ High Blood Pressure
☐ Diabetes
☐ High cholesterol
☐ Heart failure
☐ Coronary Artery Disease
☐ Heart attack (Year: _____)
☐ Angina
☐ Anemia
☐ Varicose veins
☐ Heart murmur
☐ Thyroid problems
☐ Liver Disease/Jaundice
☐ Hepatitis
☐ Abscess
Describe:

☐ Blood clots
☐ Deep vein thrombosis (DVT)
☐ Pulmonary Embolism (PE)
☐ Excessive bleeding
☐ Asthma
☐ COPD
☐ Bronchitis
☐ Pneumonia
☐ Rheumatic Fever
☐ Tuberculosis
☐ Gallbladder disease
☐ Kidney Disease
☐ Kidney stone
☐ Skin disease
Name:

☐ Osteoporosis
☐ Arthritis (osteoarthritis)
☐ Rheumatoid arthritis
☐ Lupus (SLE)
☐ Stomach Ulcer
☐ Gastric Reflux (GERD)
☐ Barrett's Esophagus
☐ Irritable Bowel Disease (IBD)
☐ Irritable Bowel Syndrome (IBS)
☐ Hemorrhoids
☐ Glaucoma
☐ Convulsions / Seizures
☐ Depression/ Anxiety
☐ Migraines
How often:

Previous cancer(s):_____

Other medical problems: _____

Have you ever undergone genetic counseling / testing? ☐ Y ☐ N Reason: _____

Patient Name_____ Age _____

If yes, do you know your BRCA 1 and/or BRCA 2 status? ☐ Y ☐ N Positive or Negative? _____

Date of last mammogram: _____ Date of last colonoscopy: _____

List of doctors who treat you for the above medical problems

Doctor Name	Specialty	Phone number

Have you ever been hospitalized for an illness? ☐ Y ☐ N

If yes,year and reason: _____

Have you ever had a blood transfusion? ☐ Y ☐ N Year and reason: _____

Have you ever undergone chemotherapy? ☐ Y ☐ N Year and reason: _____

Have you ever undergone radiation? ☐ Y ☐ N Year and reason: _____

Have you ever had Hormone Replacement Therapy (HRT)? ☐ Y ☐ N Year and reason: _____

8. **Patient's Social History**

Do you smoke? ☐ Y ☐ N Have you ever been a smoker? ☐ Y ☐ N Packs per day: _____ # of years: _____

When did you quit? _____ Any other forms of tobacco? _____

Do you use alcohol? ☐ Y ☐ N Drinks per week: _____ Type: _____

Have you ever used drugs? ☐ Y ☐ N Past type: _____ Current type: _____

Education (circle all that apply): High school / College / Graduate School

Marital status: Single / Married / Divorced / Long-term relationship (co-habitate) / Widowed

Do you exercise? ☐ Y ☐ N Hours per week and type: _____

Are you on a special diet? ☐ Y ☐ N Please describe: _____ Occupation: _____

Do you have a support system? ☐ Y ☐ N Please describe: _____

9. **Patient's Surgical History** - please list any / all surgeries you have had:

Surgery (please describe if necessary)	Year

If you had a hysterectomy:

Do you have (circle one): no ovaries / 1 remaining ovary / 2 remaining ovaries

Have you ever been advised to have any surgical procedure, which has not been done? ☐ Y ☐ N

If yes, explain: _____

Patient Name _____ Age _____

10. **Current Symptoms** - please check (✓) any / all symptoms you have now or have had in the past six months and describe if necessary:

General
- ☐ Fevers, chills, night sweats
- ☐ Excessive fatigue
- ☐ Recent weight gain/loss (how much?_____)
- ☐ Passing out or feeling like you are going to pass out

Skin
- ☐ Skin sores, rash or itching

Breasts
- ☐ Breast discharge or pain
- ☐ Lumps in the breast

Cardiovascular
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Rapid or irregular heartbeat
- ☐ Swelling of the feet, ankles

Respiratory
- ☐ Trouble breathing w / exertion (e.g., climbing stairs)
- ☐ Cough
- ☐ Bloody sputum when you cough

Gastrointestinal
- ☐ Nausea/ vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood or mucous in stool
- ☐ Black or tarry stool
- ☐ Change in bowel habits
- ☐ Heartburn or indigestion
- ☐ Bloating
- ☐ Loss of appetite
- ☐ Feeling “full” more easily when eating
- ☐ Abdominal cramps or pain

Genitourinary
- ☐ Pelvic pain
- ☐ Blood in your urine

Musculoskeletal
- ☐ Joint pain or stiffness
- ☐ Back pain

Neurology
- ☐ Headache
- ☐ Blurry vision
- ☐ Loss of consciousness / seizures
- ☐ Tremor, weakness or numbness in your hands/feet
- ☐ Problems walking

Psychiatric / Stress-related
- ☐ Insomnia
- ☐ Depression
- ☐ Mood swings
- ☐ Excessive worry
- ☐ Serious marriage problems

Endocrine
- ☐ Hot flashes
- ☐ Unusual hair growth/loss
- ☐ Abnormal thirst
- ☐ Salt cravings

Other
- ☐ Bruise easily or bleed easily
- ☐ Lumps in your groin, armpit or neck (lymph nodes)
- ☐ Any eye disease/ injury
- ☐ Any ear disease /injury
- ☐ Do you wear (circle all that apply):
  glasses/ contacts / dentures / hearing aid

Patient Name_____ Age _____