Atlanta Gynecologic Oncology

A Northside Network Provider

Gerald M. Feuer, MD, FACOG

Welcome to Atlanta Gynecologic Oncology. It is our privilege to participate in caring for your health. We strive to provide outstanding medical expertise, state of the art treatment, and compassionate care.

We believe in a team approach to health care in which the doctor and the clinical and administrative staff partner with you, the patient, to best meet your needs.

At your first visit, you'll meet Dr. Feuer and his team. A nurse will review your entire medical history and the details of your current problem. Dr. Feuer will perform a complete physical exam, including pelvic exam. He'll then explain the recommendations for treatment and answer any questions you may have about your medical problem or diagnosis. Sometimes, we'll order additional testing, like CT scans or ultrasounds, to gather more information. When surgery is the best treatment, our team will begin the scheduling process which includes a return visit for in-depth teaching with one of our nurses so you'll know what to expect.

Please review the information in this packet prior to your appointment. We have included important details about our financial and privacy policies along with a detailed history form so that we can provide the best possible care for you.

Atlanta Gynecologic Oncology employs an exceptional staff of mid-level providers with more than 45 years of combined experience in caring for gynecologic oncology patients.

We look forward to seeing you.

ATLANTA GYNECOLOGIC ONCOLOGY

GERALD A. FEUER, MD

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

COMPLETE AND ACCURATE INFORMATION ALLOWS US TO GIVE YOU THE BEST CARE POSSIBLE!

Date:_____ Referring Physician: _____

MAIN REASON FOR VISIT: ☐ pelvic mass ☐ elevated Ca125 ☐ vaginal bleeding ☐ abnormal Pap smear
☐ fibroids ☐ endometrial cancer ☐ vulvar problem _____ ☐ other_____

_____

OBSTETRICAL HISTORY: How many pregnancies have you had? _____ Vaginal deliveries _____ C-sections _____
Tubal pregnancies _____ Miscarriages _____ Abortions _____ Stillbirths _____

GYNECOLOGIC HISTORY: Age at first period: _____ Date of last menstrual period: _____
If not menstruating, stopped at age: _____ because of ☐ menopause ☐ uterus removed for _____ (reason)
Are your periods ☐ regular ☐ somewhat irregular ☐ very irregular?
How many days between the **first day** of one period and the **first day** of your next period? _____
Menstrual flow usually lasts for _____ days total and is ☐ scant ☐ moderate ☐ heavy ☐ excessive with clots.
Have you missed a period without being pregnant? ☐ Yes ☐ No
Are you currently sexually active? ☐ Yes ☐ No How do you prevent pregnancy? ☐ birth control pills ☐ condoms ☐ IUD ☐ tubal ligation
☐ menopause/uterus removed ☐ no method ☐ other _____
Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? ☐ Yes ☐ No Treatment: _____

MEDICAL PROBLEMS: Check any problem you have been diagnosed with or received treatment for:

- ☐ Anemia
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congestive heart failure (CHF)
- ☐ Angina
- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ Mitral valve prolapse
- ☐ Asthma
- ☐ Allergies/hayfever
- ☐ Bronchitis
- ☐ Emphysema
- ☐ COPD
- ☐ Diabetes
- ☐ Thyroid
- ☐ Bone disease/osteoporosis
- ☐ Previous cancer _____ (type)
- ☐ Jaundice/cirrhosis
- ☐ Gallstones
- ☐ Stomach ulcer
- ☐ Hernia
- ☐ Irritable bowel syndrome
- ☐ Colitis _____
- ☐ Chronic diarrhea
- ☐ Hemorrhoids
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Sjogren's syndrome
- ☐ Back/neck/spine problems
- ☐ Migraines _____ (how often?)
- ☐ Seizures
- ☐ Kidney failure
- ☐ Kidney stone
- ☐ Blood clot in leg or lung
- ☐ Phlebitis
- ☐ Bleeding disorder (von Willebrand)
- ☐ Varicose veins
- ☐ Glaucoma
- ☐ Skin disease _____
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Schizophrenia
- ☐ Dementia/Alzheimer's
- ☐ Other _____

Height: _____ **Current Weight:** _____ **Usual Weight:** _____ **Age:** _____

Name:_____ Date of Birth: _____

INTAKE FORM

MEDICATIONS AND SUPPLEMENTS: Please list all medications, supplements, and herbs.

	Name of medication	Dosage	When do you take it?	Who prescribed it?
Diabetes				
Heart/Blood Pressure				
Anxiety/ Depression				
Other				
Over the Counter				
Herbs/Vitamins/ Supplements				

Preferred Pharmacy: ☐ CVS ☐ Rite Aid ☐ Walmart ☐ Kroger ☐ Publix ☐ Walgreens ☐ Other _____

Address: _____ Phone: _____

ALLERGIES: Please list all allergies to **medications, foods and materials** (i.e., latex, adhesive, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.).

Medication & Reaction	Medication & Reaction

Name:_____ Date of Birth: _____

DOCTORS: Please list the doctors who care for you.

Specialty	Name	Phone	Send notes?
Gyn			☐ Yes ☐ No
Primary Care			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

*Mark yes if you would like us to send information to your other doctors after each office visit.

INFECTIOUS DISEASE: Check any of the following that you have had:

☐ Pneumonia ☐ Rheumatic Fever ☐ Tuberculosis ☐ Herpes, last outbreak _____ ☐ Syphilis ☐ Chlamydia

☐ Gonorrhea ☐ HIV ☐ Hepatitis type _____ ☐ Tubal infection (PIO) ☐ Frequent bladder or kidney infections or one treated in the hospital

☐ Abscess, describe:_____

SCREENING AND DIAGNOSTIC TESTS:

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

In the last year, have you had any ☐ X-rays ☐ CT scans ☐ MRI scans ☐ ultrasounds (sonograms)?

If yes, list body part imaged and the facility where performed: _____

_____

SURGERY: Please list <u>all</u> previous surgeries.

Year	Gyn/ Breast Surgery (any surgery on ovary, uterus, cervix, D&C, LEEP, C-section)	Year	Orthopedic Surgery (knee, hip replacement, back or bone surgery)
Year	**Other Abdominal Surgery** (colon, hernia, bowel, stomach, qallbladder)	**Year**	**Heart Surgery** (valve or bypass surgery, stents, pacemaker/defibrillator)
Year	**Other Surgery** (eye, lung, kidney, etc.)		

Have you ever been advised to have any surgical procedure which has not been done? ☐ No ☐ Yes: _____

_____

Have you been hospitalized for any illnesses? ☐ No ☐ Yes, reason/year: _____

Have you ever had a blood transfusion? ☐ No ☐ Yes, year: _____

Name:_____ Date of Birth: _____

FAMILY HISTORY: Please list any family member diagnosed with these diseases and whether they are alive (A) or deceased (D) **from this disease.**

	Close Family Members (child, sibling or parent)	**Extended Family Members** (aunts, uncles, grandparents, cousins)
Ovarian Cancer		
Breast Cancer		
Endometrial Cancer		
Cervical Cancer		
Prostate Cancer		
Colon Cancer		
Other Cancer		
Diabetes		
Tuberculosis		
Stroke		
High blood pressure		
Heart attack		

SOCIAL HISTORY:

Do you **smoke**? ☐ Yes ☐ No Packs per day: _____ Number of years: _____ When did you quit? _____

Do you use any other form of tobacco? ☐ Yes ☐ No If yes, type: _____

Do you use **alcohol**? ☐ Yes ☐ No Amount per week? _____ Type: _____

Have you ever used **drugs?** ☐ Yes ☐ No ☐ Past ☐ Present What type? _____

Do you **exercise** routinely? ☐ Yes ☐ No How often per week? _____ What type? _____

Do you have concerns about your **personal safety**, the personal safety of anyone in your home, or in the security of your property? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner

Ages of children: _____

Education: ☐ High school ☐ College ☐ Graduate School

Occupation: _____ ☐ Retired ☐ Disabled due to _____

Name: _____ Date of Birth: _____

SYSTEM REVIEW: Check any of the following symptoms that you have now or have had in the past six months.

General	☐ fevers	☐ weight loss ____lbs	☐ weight gain ____lbs
	☐ weakness/excessive fatigue		
Skin	☐ sores	☐ rashes	☐ itching
	☐ new moles or freckles	☐ loss of skin pigment	
Neurologic	☐ seizures/convulsions	☐ tremor	☐ severe headaches
	☐ numbness/tingling	☐ loss of consciousness/fainting	
Eyes, Ears, Nose, Throat	☐ ringing in the ears	☐ any eye disease or injury _____	
	☐ chronic sinus infections	☐ any ear disease or injury _____	
	☐ frequent throat infections	Do you wear glasses? ☐ Yes ☐ No contacts? ☐ Yes ☐ No	
		dentures? ☐ Yes ☐ No hearing aid? ☐ Yes ☐ No	
Breasts	☐ nipple discharge	☐ change in breast size	☐ new or changing lumps
Respiratory	☐ shortness of breath	☐ chronic or frequent cough	☐ bloody sputum
Cardiovascular	☐ chest pain	☐ rapid/irregular heartbeat	☐ swelling of feet or ankles
Gastrointestinal	☐ diarrhea	☐ constipation	☐ nausea
	☐ vomiting	☐ heartburn or indigestion	☐ difficulty swallowing
	☐ blood in stool	☐ black or tarry stool	☐ abdominal cramps or pain
	☐ unable to control bowels	☐ urgency of bowel movements	
Gynecologic	☐ pelvic pain	☐ bleeding/spotting between periods	
	☐ painful sex	☐ bleeding/spotting after sex	☐ painful periods
	☐ vaginal irritation/itching	☐ vaginal discharge	☐ vaginal dryness
	☐ vulvar irritation/itching	☐ bulging sensation in the vagina	
	☐ sores or lumps around the vulva or vagina		☐ lumps in the groin
Urinary	☐ frequent urination	☐ painful urination	☐ night urination
	☐ dribbling of urine	☐ sudden urgent need to urinate	
	☐ bedwetting	☐ loss of urine with sneezing or coughing	
Musculoskeletal	☐ back pain	☐ joint pain/stiffness	☐ leg cramps or limp
	☐ muscle weakness		
Endocrine	☐ unusual hair growth	☐ hair loss	☐ abnormal thirst
	☐ salt cravings	☐ hot flashes	
Psychiatric	☐ nightmares	☐ insomnia	☐ depression
	☐ excessive worry/stress/tension		

Name:_____ Date of Birth: _____