

ATLANTA GYNECOLOGIC ONCOLOGY

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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 Have you ever used birth control pills? Yes No

Are you currently sexually active? Yes No Have you ever used hormone replacement therapy? Yes No

menopause/uterus removed no method other _____

Date of last Pap smear: _____ Have you ever had an abnormal Pap smear? Yes No Treatment: _____

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 (PID) Frequent bladder or kidney infections or one treated in the hospital

Abscess, describe: _____

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Previous cancer _____ (type) | <input type="checkbox"/> Kidney disease _____ (type) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Autoimmune disease _____ (type) | <input type="checkbox"/> Blood clot in leg or lung |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stomach ulcer | <input type="checkbox"/> Bleeding disorder _____ (type) |
| <input type="checkbox"/> Congestive heart failure (CHF) | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Hernia | <input type="checkbox"/> Migraines _____ (how often?) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Emphysema or COPD | <input type="checkbox"/> Colitis _____ | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back/neck/spine problems | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dementia or Alzheimer's Disease |
| <input type="checkbox"/> Bone disease/osteoporosis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin disease _____ |

Name: _____

Date of Birth: _____

SURGERY: Please list all 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, gallbladder)	Year	Heart Surgery (valve or bypass surgery, stents, pacemaker/defibrillator)
Year	Other Surgery (eye, lung, kidney, etc.)	Year	

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: _____

DOCTORS: Please list the doctors who care for you.

Specialty	Name	Phone
Gyn		
Primary Care		

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

SCREENING AND DIAGNOSTIC TESTS:

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

Date of last bone density/DEX scan: _____

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: _____

Name: _____ Date of Birth: _____

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: _____

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		
Melanoma		
Pancreatic Cancer		
Colon Cancer		
Other Cancer		
Diabetes		
Tuberculosis		
Stroke		
High blood pressure		
Heart attack		

SOCIAL HISTORY:

Marital Status: Single Married Divorced Widowed Domestic partner

Ages of children: _____

Occupation: _____ Retired Disabled due to _____

Education: High school College Graduate School

Do you have a **Living Will** or **Advanced Directive**? _____

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 the security of your property? Yes No

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

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

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