GYNECOLOGIC CANCER INSTITUTE
of CHICAGO

Gynecologic Oncology New Patient Questionnaire

Date: ____________________ Name: ____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Other DOB: ______________________________________

Age: ____________________ Home Phone: ____

Work Phone: ______________________________________ Cell Phone: ____________________________________

Occupation: ______________________________________ Emergency Contact Name: ____________________

Emergency Contact Phone Number (not your own): ____

Referring Physician: ____

Referring Physician's Address: ____________________ Phone #: ___________________________________

Fax #: ___________________ I would like my medical records sent to this physician: ☐ Y ☐ N

Primary Physician: ____

Primary Physician Address: ____

Phone #: ____ Fax #: ____

I would like my medical records sent to this physician: ☐ Y ☐ N

Other Physician: ____

Other Physician Address: ____

Phone #: ____ Fax #: ____

I would like my medical records sent to this physician: ☐ Y ☐ N

Reason for the visit today? ____

How long have you been experiencing this problem? ____

Have you had any of the following tests done for this problem (Check all that apply)

	Which facility?	Are results available?*
☐ Ultrasound or Sonogram		
☐ CT or Cat Scan		
☐ Chest X-Ray		
☐ Barium Enema		
☐ Tissue Biopsy		
☐ Laboratory Tests		
☐ Other:		

*Please note that all diagnostic results pertaining to your current problem must be available in order to have a complete consultation

Past Medical History

Have you ever been hospitalized for a medical condition? ☐ Y ☐ N Date: ____________________

Reason for hospitalization: ____

Do you have or have you had any of the following? (Check all that apply)

	Yes	No
High blood pressure		
Diabetes		
Asthma		
Other lung disease		
Stroke		
Heart disease		
Blood clot		

	Yes	No
Kidney disease		
Liver disease		
Cancer		
Blood disorder		
Mental/ Psychological disorder		
Other:		
Other:		

If yes, please describe? ____

____

____

____

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Past Surgical History

Have you ever had surgery? ☐ Y ☐ N

If yes, please list procedure and dates: ____

____

____

Did you experience any complications, such as:

Unexpected bleeding: ☐ Y ☐ N Problems with anesthesia: ☐ Y ☐ N Infection: ☐ Y ☐ N

Medications (Include over the counter pills or vitamins/herbals/complementary):

____

____

____

Allergies

To medications ____

To food or other ____

Preventative Screening

Last Mammogram ____

Were the results normal? ☐ Y ☐ N

Last Colonoscopy ________________________________ Were the results normal? ☐ Y ☐ N

Last DEXA/bone density scan ______________________ Were the results normal? ☐ Y ☐ N

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Gynecologic History

Age of first menstrual period ______ Last PAP smear _____Were the results normal? ☐ Y ☐ N

Pre-menopausal: Date of last period ________ Duration of menstrual cycles ____________________

Post-menopausal: What age was your last menstruation/menopause (change of life)? _________

Any menopausal symptoms ☐ Y ☐ N Explain: ____

Are you sexually active? ☐ Y ☐ N

Have you ever used/do you use contraception? ☐ Y ☐ N What type? ____________________

Have you ever had:

Abnormal Pap ☐ Y ☐ N Abnormal vaginal bleeding ☐ Y ☐ N

Uterine Fibroid ☐ Y ☐ N Pelvic Infection or sexually transmitted disease ☐ Y ☐ N

Obstetrical History

How many times have you been pregnant?________ # of miscarriages_____ # of terminations____

Month/Year of Births	Vaginal or c-section	Premature or Full term

History

With whom do you live? ____

How often do you exercise?____________________Are you on a special diet____________________

Do you smoke/have you ever smoked? ☐ Y ☐ N

Packs per day ________________ How many years ___________When did you quit?____________

Do you drink alcohol ☐ Y ☐ N How much/how often? ________________________________

Have you ever used illegal drugs? ☐ Y ☐ N Explain: ____________________________________

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Family History

(i.e. cancers and type, heart disease, stroke, hypertension, diabetes, etc. and age of onset)

Relative	Age Now	Age of Death	Any Illnesses
Father			
Mother			
Sister/ Brother			
Sister/ Brother			
Sister/ Brother			
Sister/ Brother			
Daughter/Son			
Daughter/Son			
Daughter/Son			
Spouse			

Do you have ANY other blood relatives with cancer (who/what type)?________________________

____

Review of Systems

Do you have any of the following now or recently?	Yes	No	Explain
Weight loss/gain, unusual fatigue, night sweats, loss of appetite, fainting			
Eye of lid problems, change in vision			
Change in hearing, ringing in ears			
Nasal congestion, nosebleeds, sore throat, cold symptoms, dental problems, hoarseness			
Shortness of breath, cough, wheezing, coughing up blood			
Chest pain/pressure with exertion, palpitations, swelling in legs/ankles			
Breast lump or soreness			
Nausea vomiting, heartburn, diarrhea, constipation			
Difficulty urinating, pain with urination, blood in urine			
Increased frequency and/or waking up at night to urinate, leaking urine			
Irregular vaginal bleeding, heavy periods			
Unusual vaginal discharge, pain with intercourse			
Muscle pain or weakness, joint pain, stiffness			
Mood swings, depression, anxiety attacks			

The above information will be a part of your medical record and will be protected according to the privacy regulations under the Health Information Portability and Privacy Act (HIPPA).

Patient's signature ____ Date _______________

Reviewed by ______________________________________ MD/ MD resident/ APN/ RN/ student

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THIS PAGE FOR OFFICE USE ONLY

Vital Signs: Taken By: ______________________ initials

Temp ______________ BP ______________ HR ______________ RR ______________

Height ______________ inches Weight ______________ lbs BSA ______________

Pain (0-10) ______________ Location ______________

HPI:

General Physical Examination

General ______________

Skin ______________

HEENT ______________

Neck ______________

Breast ______________

Lungs ______________

CV ______________

Abdomen ______________

Lymph nodes ______________

Extremities ______________

Musculoskeletal ______________

Neurologic ______________

Pelvic: External Genitalia ______________

Vagina ______________

Cervix ______________

Uterus ______________

Adnexa ______________

Rectum ______________

PAP taken ☐ Y ☐ N

Other ______________

Assessment ______________

____

Plan ______________

____

____

Note IN EPIC ☐ Y ☐ N Note Dictated ☐ Y ☐ N

Signature ______________ Title ______________ Date

Attending MD ______________