GYNECOLOGIC ONCOLOGY CLINIC CONFIDENTIAL HEALTH HISTORY

Directions: Please select if you currently have or have had any of the following in the past year.

General

- ☐ Chills
- ☐ Sweats
- ☐ Fever
- ☐ Tiredness
- ☐ Weakness
- ☐ Lack of appetite
- ☐ Weight gain
- ☐ Weight loss
- ☐ Problems sleeping

Respiratory

- ☐ Asthma or wheezing
- ☐ Difficulty breathing
- ☐ Any trouble with lungs
- ☐ Pleurisy or pneumonia
- ☐ Cough up blood (ever)

Head-Eyes-Ears-Nose-Throat

- ☐ Dry eyes or mouth
- ☐ Bleeding gums - frequent or constant
- ☐ Blurred vision
- ☐ Sneezing or runny nose
- ☐ Nosebleeds - frequent
- ☐ Ear disease
- ☐ Impaired hearing
- ☐ Dizziness or sensation of room spinning
- ☐ Frequent or severe headache
- ☐ Chronic sinus trouble

Hematologic

- ☐ Are you slow to heal after cuts?
- ☐ Anemia
- ☐ Phlebitis or blood clots in veins
- ☐ Have you had difficulty with bleeding excessively after tooth extraction?
- ☐ Have you had abnormal bruising or bleeding?

Gastrointestinal

- ☐ Vomiting blood or food
- ☐ Gallbladder disease
- ☐ Change in appetite
- ☐ Hepatitis/Jaundice
- ☐ Painful bowel movements
- ☐ Black stools
- ☐ Hemorrhoids or piles
- ☐ Recent change in bowel habits
- ☐ Frequent diarrhea
- ☐ Heartburn or indigestion
- ☐ Cramping or pain in the abdomen
- ☐ Food sticking in the throat
- ☐ Ulcer or gastritis
- ☐ Liver problems

Genitourinary

- ☐ Loss of urine
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Night time urinating
- ☐ Kidney trouble
- ☐ Problem stopping/starting flow of urine
- ☐ Sexual dysfunction
- ☐ STD/Symptoms/Risk
- ☐ AIDS/Symptoms/Risk

Cardiovascular

- ☐ Chest pain, pressure, or tightness
- ☐ Shortness of breath with walking or lying down
- ☐ Difficulty walking two blocks
- ☐ Swelling of hands, feet or ankles
- ☐ Awakening in the nights smothering
- ☐ Palpitations
- ☐ Heart murmur
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Heart failure

Skin

- ☐ Skin Disease
- ☐ Jaundice
- ☐ Hives, eczema or rash

Neck

- ☐ Stiffness
- ☐ Enlarged glands

Neuro-Psychiatric

- ☐ Transient blindness
- ☐ Tremor
- ☐ Numbness in fingers
- ☐ Weakness
- ☐ Convulsions
- ☐ Paralysis
- ☐ Problem with coordination
- ☐ Domestic violence
- ☐ Have you ever had counseling for your mental health?
- ☐ Have you ever been advised to see a psychiatrist?
- ☐ Have you ever had fainting spells?
- ☐ Depression symptoms (difficulty sleeping, loss of appetite, loss of interest in activities, feelings of hopelessness)

Locomotor-Musculoskeletal

Stiffness or pain in the following:

- ☐ Fingers
- ☐ Hands
- ☐ Wrist
- ☐ Toes
- ☐ Hips
- ☐ Knees
- ☐ Elbows
- ☐ Feet
- ☐ Shoulders
- ☐ Neck
- ☐ Back
- ☐ Temporomandibular Joint (TMJ)

Allergies (If yes, what type of reaction?)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Medications

_____

_____

_____

_____

_____

PATIENT ID: DOB:

Endocrine

- ☐ Hormone therapy
- ☐ Change in hat or glove size
- ☐ Change in hair growth
- ☐ Have you become colder than before?
- ☐ Has your skin become dryer than before?
- ☐ Thyroid
- ☐ Diabetes

Gynecological

First day of last period:_____ Age periods started: _____
Number of pregnancies:_____ Number of births: _____
Date of last pap and results:_____
_____
Have you ever had an abnormal pap smear? _____
Have you ever taken hormone replacement therapy (HRT)?
If yes, give type, duration, and when stopped: _____
Type:_____
Duration: _____
Stopped: _____

History of Past Illness

Childhood:

- ☐ Measles ☐ Mumps ☐ Chicken pox
- ☐ Congenital abnormalities ☐ Tuberculosis
- ☐ Rheumatic fever or heart disease

Have you had any serious illness? ☐ Yes ☐ No
Have you ever been hospitalized or under medical care for more than two weeks? ☐ Yes ☐ No
If answered yes to either question, please explain reason:
_____
_____
_____

Have you ever had a transfusion? ☐ Yes ☐ No

Operations

Have you ever had any surgery? (explain below)

- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Ovaries removed
- ☐ Other
- ☐ Gallbladder
- ☐ Joint replacement
- ☐ Bypass (explain below)

_____
_____

Have you ever had problems with malignant hyperthermia?
☐ Yes ☐ No

Social History

- ☐ Recreational drug use
- ☐ Problems with sexual function
- ☐ Drink coffee? Amount per week _____
- ☐ Drink tea? Amount per week _____
- ☐ Drink soda? Amount per week _____
- ☐ Drink alcohol? Amount per week _____
- ☐ Use tobacco? If yes, years smoked?_____
  Packs per day _____
  Quit _____ years ago
- ☐ Do you vape ☐ Yes ☐ No

Education

- ☐ Grade school
- ☐ High school
- ☐ College
- ☐ Post graduate

Has any blood relative had any type of cancer? ☐ Yes ☐ No If "Yes," list specific information below:

Relationship	Paternal	Maternal	Age at initial diagnosis	Type of cancer	Current status of relative

Has any blood relative had any of the following? ☐ Yes ☐ No If "Yes," list specific information below:

	Father	Mother	Sister(s)	Brother(s)	Other
Stroke					
Diabetes					
Heart attack					
High blood pressure					
Bleeding problems					
Crippling arthritis					

Source of information (if other than patient): _____ What is the best contact number for you? _____
Patient's Signature: _____ Date: _____ Email address: _____
Physician's Signature: _____ Date: _____ Time: _____