CancerCare NORTHWEST

New Patient - Gynecology History Questionnaire

Today's Date: _____

Patient Name: _____ Birth date: _____ Age: _____

Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Are we allowed to discuss your medical care with your emergency contact? Yes No

Do you wish to restrict access to your health information? **Yes** (*see line below)* **No**
If yes, please obtain a *Restriction Request Form* from the receptionist.

Referring Physician: _____ Primary Physician: _____

Past Medical History:
Please describe and provide the year of the occurrence.
Major illnesses and hospitalizations:

Operations:

Allergies:

Medications:

Personal history of the following conditions:

Yes	*No*	*Unsure*		*Yes*	*No*	*Unsure*	
☐	☐	☐	Heart disease	☐	☐	☐	Depression
☐	☐	☐	Hypertension	☐	☐	☐	Cancer
☐	☐	☐	Stroke	☐	☐	☐	Chemotherapy
☐	☐	☐	Diabetes	☐	☐	☐	Radiation therapy
☐	☐	☐	Alcoholism				

Obstetric/Gynecological History:
Age at the time of your first period: _____

Number of pregnancies: _____ Number of children: _____ Cesarean section ☐ Yes ☐ No

Are you in menopause? ☐ Yes ☐ No If yes, at what age? _____ Are you on hormone therapy? ☐ Yes ☐ No

Beginning of last menstrual period: _____ Was it normal? ☐ Yes ☐ No

Last pelvic exam and Pap smear: _____ History of abnormal Pap smear? ☐ Yes ☐ No

Method of contraception: _____

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Family History:

Yes	*No*	*Unsure*		If yes, which family member(s)
☐	☐	☐	Heart disease	_____
☐	☐	☐	Hypertension	_____
☐	☐	☐	Stroke	_____
☐	☐	☐	Diabetes	_____
☐	☐	☐	Alcoholism	_____
☐	☐	☐	Depression	_____
☐	☐	☐	Suicide	_____
☐	☐	☐	Other psychiatric illness	_____
☐	☐	☐	Colon cancer	_____
☐	☐	☐	Breast cancer	_____
☐	☐	☐	Ovarian cancer	_____
☐	☐	☐	Uterine cancer	_____
☐	☐	☐	Osteoporosis	_____

Other: _____

Symptom Checklist:

1. *General*

Yes	*No*	*Unsure*	
☐	☐	☐	Recent weight change
☐	☐	☐	Fever or chills or night sweats
☐	☐	☐	Dizziness or light-headedness
☐	☐	☐	Fainting
☐	☐	☐	Headaches
☐	☐	☐	Fatigue

2. *Eye, ear, nose, and throat*

☐	☐	☐	Glaucoma
☐	☐	☐	Blurred or double vision
☐	☐	☐	Hearing problems

3. *Cardiovascular*

☐	☐	☐	Palpitations
☐	☐	☐	Chest pain
☐	☐	☐	High cholesterol level
☐	☐	☐	Rheumatic fever
☐	☐	☐	Shortness of breath at night
☐	☐	☐	Difficulty breathing when lying flat
☐	☐	☐	Pain in legs with activity
☐	☐	☐	Blood clots

4. *Respiratory*

☐	☐	☐	Cough
☐	☐	☐	Sputum production
☐	☐	☐	History of pneumonia or pleurisy

5. *Respiratory, continued*

Yes	*No*	*Unsure*	
☐	☐	☐	Shortness of breath with activity
☐	☐	☐	History of wheezing or asthma
☐	☐	☐	History of pulmonary emboli (blood clot to the lung)

6. *Hematologic*

☐	☐	☐	Personal or family history of easy bruising or bleeding
☐	☐	☐	Anemia
☐	☐	☐	History of blood transfusion

7. *Gastrointestinal*

☐	☐	☐	Abdominal pain
☐	☐	☐	Nausea or vomiting
☐	☐	☐	Bloating or food intolerance
☐	☐	☐	Ulcer disease
☐	☐	☐	Diarrhea
☐	☐	☐	Constipation
☐	☐	☐	Blood in stool
☐	☐	☐	History of binge eating, purging, or laxative use for weight control

8. *Musculoskeletal*

☐	☐	☐	Neck pain
☐	☐	☐	Back pain
☐	☐	☐	Joint problems
☐	☐	☐	Muscle weakness

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9. *Neuropsychiatric*

Yes	*No*	*Unsure*	
☐	☐	☐	Seizures
☐	☐	☐	Tremor
☐	☐	☐	Difficulty with walking
☐	☐	☐	Memory loss
☐	☐	☐	Anxiety or stress
☐	☐	☐	Depression
☐	☐	☐	Difficulty sleeping
☐	☐	☐	Hospitalization for psychiatric problems

10. *Genitourinary*

☐	☐	☐	Pain or burning with urination
☐	☐	☐	Difficulty starting or holding urine
☐	☐	☐	Urinary or bladder infections
☐	☐	☐	Kidney or bladder infections
☐	☐	☐	Blood in the urine
☐	☐	☐	History of gonorrhea, chlamydia, or syphilis
☐	☐	☐	History of genital herpes
☐	☐	☐	History of genital warts
☐	☐	☐	HIV status tested. If yes, date last tested:

10. *Genitourinary, continued*

Yes	*No*	*Unsure*	
☐	☐	☐	History of infertility
☐	☐	☐	Current sexual issues or problems
☐	☐	☐	History of sexual abuse
☐	☐	☐	Recent (within six months) exposure to sexually transmitted disease

11. *Reproductive*

☐	☐	☐	Possibly pregnant
☐	☐	☐	Change in menstrual pattern
☐	☐	☐	Unusual vaginal bleeding
☐	☐	☐	Pain with intercourse
☐	☐	☐	Vaginal itching or change in odor or color of discharge
☐	☐	☐	Other (describe)_____

_____

_____

_____

12. *Breasts*

☐	☐	☐	Lumps
☐	☐	☐	Tenderness
☐	☐	☐	Drainage from nipple

Other History:

Family Status

☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Separated ☐ Widow(er)

Number of children _____ Minors _____ Adults _____

Occupation_____ ☐ Full time ☐ Part time ☐ Retired

Do you live alone? ☐ Yes ☐ No

If no, who do you live with? _____

Advance Directive

☐ Yes	☐ No	Are you interested in more information about a Washington Durable Power of Attorney for Health Care or a Living Will?
☐ Yes	☐ No	Do you currently have Washington Durable Power of Attorney for Health Care Living Will?
☐ Yes	☐ No	Do we have a copy?
☐ Yes	☐ No	Do you wish to make any changes?
☐ Yes	☐ No	Do you have a legal guardian?

Diet

☐ Yes	☐ No	Do you follow a special diet? If yes, what type? _____
☐ Yes	☐ No	Have your eating habits changed recently? If yes, describe _____
☐ Yes	☐ No	Have you had a recent weight change? If yes, how much? _____Was it intentional?___

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Habits

□ Yes □ No Do you smoke? □ Cigarettes □ Pipe □ Cigar □ Chew How much? ____ How long?____

□ Yes □ No Did you smoke in the past? How much? _____ How long? _____

□ Yes □ No Do you use alcohol?

How much? □ 1-2 □ 3-5 □ more than 5 drinks

How often? □ Daily □ Weekly □ Monthly

□ Yes □ No Do you use recreational drugs?

If yes, □ Marijuana □ Cocaine □ Heroin □ Other

In the last year, have you felt you should cut down or stop:

Drinking? □Yes □No Smoking? □Yes □No Using drugs? □Yes □No

Social and Coping Issues

□ Yes □ No Do you have cultural or religious practices we should be aware of? _____

□ Yes □ No Are you now or have you ever been in a relationship that causes you fear, pain, or injury?
If yes, describe _____

□ Yes □ No Do you have good support from family or friends?

Communication

Are you able to:	**English**		**Other language** _____	
Read	□ Yes	□ No	□ Yes	□ No
Speak	□ Yes	□ No	□ Yes	□ No
Write	□ Yes	□ No	□ Yes	□ No
Understand	□ Yes	□ No	□ Yes	□ No

Functional Activities of Daily Living

Do you have problems sleeping? □ Yes □ No

Do you currently use any of the following (check all that apply)

□ Glasses □ Wheelchair □ Contact lenses □ Cane □ Hearing aid

□ Walker □ Crutches □ Dentures (upper, lower or partial?)_____

□ Commode □ Braces (back, leg or arm?)_____

□ Special bed □ Artificial eye □ Prosthesis (arm or leg?) _____ □ Other _____

Do you have difficulty completing any of the following activities alone?

Bathing	□ Yes	□ No	Dressing/Undressing	□ Yes	□ No
Toileting	□ Yes	□ No	Eating	□ Yes	□ No
Walking 50 yards or more	□ Yes	□ No	Stair climbing	□ Yes	□ No

Do you need help with the following?

Taking medications	□ Yes	□ No
Shopping	□ Yes	□ No
Finances	□ Yes	□ No
Telephone	□ Yes	□ No
Preparing meals	□ Yes	□ No
Transportation	□ Yes	□ No
Laundry	□ Yes	□ No
Housekeeping	□ Yes	□ No

Reviewed by _____ **Date**_____

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