Name:_____ DOB: _____ Acc#: _____

Ironwood Women's Centers

Ironwood Cancer & Research Centers

Gynecologic Oncology Questionnaire

What problem brought you here today? _____

When did this problem begin? _____

Supplemental Gynecologic History

If pre-menopausal, when did your last menses begin? _____ ☐ Post-menopausal

When was your last pap smear/HPV test? _____

Was it ☐ Normal or ☐ Abnormal?

In the past have you had any abnormal pap smears/HPV tests? ☐ Yes ☐ No

If yes, when? _____ Result: _____

Did you undergo a colposcopy ± biopsy? ☐ Yes ☐ No

If yes, when? _____ Result: _____

Did you undergo a LEEP (Loop Electrosurgical Excision Procedure)? ☐ Yes ☐ No

If yes, when? _____ Result: _____

Have you ever had or been diagnosed with any of the following?

Fibroids	☐ Yes ☐ No	Year: _____	Treatment: _____	
Endometriosis	☐ Yes ☐ No	Year: _____	Treatment: _____	
Ectopic Pregnancy	☐ Yes ☐ No	Year: _____	Treatment: _____	

Are you currently taking or have you ever taken any of the following hormonal medications?

Birth Control Pills:	☐ Yes	☐ No	Duration:	Side Effects:
Estrogen:	☐ Yes	☐ No	Duration:	Side Effects:
Tamoxifen:	☐ Yes	☐ No	Duration:	Side Effects:
Raloxifene (Evista):	☐ Yes	☐ No	Duration:	Side Effects:
Arimidex (Anastrazole):	☐ Yes	☐ No	Duration:	Side Effects:
Letroxole (Femara):	☐ Yes	☐ No	Duration:	Side Effects:
Exemstane (Aromasin):	☐ Yes	☐ No	Duration:	Side Effects:
Prempro:	☐ Yes	☐ No	Duration:	Side Effects:
Other: _____	☐ Yes	☐ No	Duration:	Side Effects:

Name:_____ DOB: _____ Acc#: _____

Supplemental Social History

With whom do you live? _____

Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes, 5 times a week or more

If yes, what do you do? _____

Are you sexually active? ☐ Yes ☐ No

If yes, with ☐ Men ☐ Women ☐ Both ?

Supplemental Family History

Are you aware of BRCA1/2 or other genetic susceptibility to cancer in your family? ☐ Yes ☐ No

If yes, which gene(s)?_____ Are you adopted? ☐

Has any blood relative had **ovarian cancer**? ☐ Yes ☐ No (if yes, list specific information below)

Relationship: Maternal Paternal Age at diagnosis Diagnosis Current status of relative

_____

_____

_____

Has any blood relative had **endometrial cancer**? ☐ Yes ☐ No (if yes, list specific information below)

Relationship: Maternal Paternal Age at diagnosis Diagnosis Current status of relative

_____

_____

_____

Has any blood relative had **breast cancer**? ☐ Yes ☐ No (if yes, list specific information below)

Relationship: Maternal Paternal Age at diagnosis Diagnosis Current status of relative

_____

_____

_____

Has any blood relative had **colorectal cancer**? ☐ Yes ☐ No (if yes, list specific information below)

Relationship: Maternal Paternal Age at diagnosis Diagnosis Current status of relative

_____

_____

_____

Has any blood relative had **any other type of cancer**? ☐ Yes ☐ No (if yes, list specifics below)

Relationship: Maternal Paternal Age at diagnosis Diagnosis Current status of relative

_____

_____

_____