Ironwood Women's Centers
Ironwood Cancer & Research Centers

Name (Last, First): _____

Date of Birth: _____ Date of Service: _____

Gynecologic Oncology Questionnaire

Please list all Doctors/Health Care Providers you would like to receive a copy of information regarding your care:

_____

PRIMARY PROBLEM

What brings you to see us today? _____

When did this problem begin? _____

Have you had any of the following tests?

	Yes?	When and Where
Abnormal biopsy	□	
CT Scan	□	
MRI Scan	□	
PET Scan	□	
Pelvic Ultrasound	□	

UPDATED MEDICAL/ SURGICAL HISTORY

Are there any changes to your medical or surgical history since you first filled out the Ironwood Patient History Form?

□ Yes □ No If yes, please specify: _____

Are there any changes to your medication or allergy list since you first filled out the Ironwood Patient History Form?

□ Yes □ No If yes, please specify: _____

Any implanted devices (pacemakers, pumps, etc.) □ Yes □ No

SUPPLEMENTAL SOCIAL HISTORY

With whom do you live? □ Alone _____

Do you exercise? □ Never □ Sometimes □ 30 minutes, 3x/week or more

If yes, what do you do? _____

Have you experienced 10 lbs (or greater) weight loss or gain in past 3 months? □ Yes □ No

Do you have problems with mobility (use a wheelchair, cane, or walker)? □ Yes □ No

If yes, describe issue and/or device used: _____

Do you feel unsteady? □ Yes □ No Have you had a fall in the past year? □ Yes □ No

Are you in a relationship where you are being threatened or hurt? □ Yes □ No

Are there any religious considerations that would keep you from receiving blood products? □ Yes □ No

If yes, please specify: _____

SUPPLEMENTAL GYNECOLOGIC HISTORY

Are you possibly pregnant now? □ Yes □ No

Do you plan or desire to have children in the future? □ Yes □ No

Are you in menopause? □ Yes □ No

Are you sexually active? □ No □ Yes, with men □ Yes, with women □ Yes, with both

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Number of Pregnancies:____ Live births:____ Vaginal births:____ Cesarean births:____ Ectopic Pregnancies:____

Last menstrual period: _____

Are you . . . (Circle applicable treatment)

Currently using any form of birth control (pill / ring / IUD / implant)? □ Yes □ No

Currently taking any hormone replacement therapy (vaginal / oral / patch / gel)? □ Yes □ No

Currently taking any Tamoxifen, Raloxifene (Evista), Arimidex (Anastrazole),
Letroxole (Femara), or Exemstane (Aromasin)? □ Yes □ No

Before this problem began, when was your last gyn exam: _____

Before this problem began, when was your last pap: _____

Was it □ Normal or □ Abnormal? Have you ever had an abnormal pap? □ Yes □ No

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

If yes, when? _____ Result: _____

Did you undergo a LEEP (Loop Electrosurgical Excision Procedure) or a Conization Procedure? □ Yes □ No

If yes, when? _____ Result: _____

Have you ever had or been diagnosed with: Fibroids / Endometriosis / Ectopic Pregnancy? (Circle diagnosis)

□ Yes □ No If yes, please specify Year: _____ Treatment: _____

FAMILY HISTORY OF CANCER **Adopted?** □ Yes □ No

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

Has any blood relative had ovarian, uterine, breast or colon cancers? □ Yes □ No, If yes, please specify below.

Has any blood relative had any other type of cancer? □ Yes □ No, If yes, please specify below.

Relative (Specify Maternal/Paternal)	Type of cancer	Age when diagnosed	Alive?

SUPPLEMENTAL ADVANCE DIRECTIVES

Do you have a Living Will? □ Yes □ No

If no, would you like information about how to establish a Living Will? □ Yes □ No

Do you have a Health Care Surrogate? □ Yes □ No

If yes, please provide the person/s name and phone number.

Name: _____ Number: _____

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REVIEW OF SYSTEMS: in the past 3 months, have you experienced any of the following:

CONSTITUTIONAL

Pain	☐ Yes	☐ No
Lack of appetite	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Lethargy/fatigue	☐ Yes	☐ No
Night sweats/chills	☐ Yes	☐ No
Weight loss	☐ Yes	☐ No

HEAD/EYES/ EARS/NOSE /THROAT/NECK

Ringing in ears	☐ Yes	☐ No
Blurry/Decreased Vision	☐ Yes	☐ No
Difficulty hearing	☐ Yes	☐ No
Nosebleeds	☐ Yes	☐ No
Mouth Ulcers	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No
Swollen lymph nodes or glands	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Masses or lumps	☐ Yes	☐ No

SKIN

Chronic skin condition	☐ Yes	☐ No
Rash	☐ Yes	☐ No

BREAST

Breast Lump	☐ Yes	☐ No
Nipple Discharge or change	☐ Yes	☐ No
Breast color change	☐ Yes	☐ No
Breast pain	☐ Yes	☐ No
Armpit lump	☐ Yes	☐ No

CARDIOPULMONARY

Ankle swelling	☐ Yes	☐ No
Sleep with head elevated	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Short of breath when walking	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Cough	☐ Yes	☐ No
Blood in phlegm	☐ Yes	☐ No
Wheezing/asthma	☐ Yes	☐ No
Use CPAP at home	☐ Yes	☐ No
Use Oxygen at home	☐ Yes	☐ No

HEMATOLOGIC/ LYMPH

Bruising	☐ Yes	☐ No
Enlarged lymph nodes	☐ Yes	☐ No
Lymphedema	☐ Yes	☐ No

MOVEMENT/MUSCULOSKELETAL

Painful joints	☐ Yes	☐ No
Bone pain	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No
Decreased range of motion	☐ Yes	☐ No
Wheelchair, cane or walker	☐ Yes	☐ No

GASTROINTESTINAL

Nausea or vomiting	☐ Yes	☐ No
Abdominal pain	☐ Yes	☐ No
Diarrhea or frequent stools	☐ Yes	☐ No
Blood in stool	☐ Yes	☐ No
Trouble swallowing	☐ Yes	☐ No
Yellow skin/jaundice	☐ Yes	☐ No
Constipation	☐ Yes	☐ No

GENITOURINARY

Incontinence of urine	☐ Yes	☐ No
Incontinence of stool	☐ Yes	☐ No

ENDOCRINE

Hot flashes	☐ Yes	☐ No
Other endocrine problems	☐ Yes	☐ No

PSYCHIATRIC

Depression	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Body Dysmorphic Disorder	☐ Yes	☐ No
Post Traumatic Stress Syndrome	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No

GYNECOLOGIC

Vaginal bleeding	☐ Yes	☐ No
Vaginal discharge	☐ Yes	☐ No
Vaginal dryness	☐ Yes	☐ No
Irregular periods	☐ Yes	☐ No
Painful Intercourse	☐ Yes	☐ No
Painful periods	☐ Yes	☐ No
Menopausal	☐ Yes	☐ No

NEURO

Frequent or severe headaches	☐ Yes	☐ No
Migraines	☐ Yes	☐ No
Claustrophobia	☐ Yes	☐ No
Numbness/tingling	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Seizures	☐ Yes	☐ No

ACKNOWLEDGMENT OF NOTICE OF PRIVACY POLICY

I have received a copy of Ironwood's Notice of Privacy Policy.

I ☐ do not ☐ Do___ wish to make further restrictions on the use of my protected health information.

Additional restrictions: _____

_____

Patient Signature: _____ **Date:** _____

Patient Name _____ Date of Birth _____