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 (Anastrozole): 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:
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
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

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