# Gynecologic Oncology Health History Questionnaire:

FIRST PHYSICIANS GROUP
*of Sarasota Memorial Health Care System*

Name_______________________________________________ Date of birth__________________________

Address______________________________________________________________________________

Local phone number_________________________ Alternative phone number_________________

Please describe what problem or concern brought you to our office today:

☐ Primarily to establish care ☐ Other (please briefly describe)_________________________________________

| Special Communication Needs: | | |
|---|---|---|
| Language preference: | | |
| If 'yes' to any of the questions below, how can we assist? | | |
| Visual impairment | ☐ Yes ☐ No | |
| Hearing impairment | ☐ Yes ☐ No | |
| Speech impairment | ☐ Yes ☐ No | |
| Cognitive impairment | ☐ Yes ☐ No | |
| Sensory impairment | ☐ Yes ☐ No | |

| Personal Health History | |
|---|---|
| Please check past(P) or current(C) problems or conditions | |
| P☐ C☐ **Cancer** Type: | P☐ C☐ Atrial Fibrillation |
| P☐ C☐ **Breast Problems** Type: | P☐ C☐ Seizures |
| P☐ C☐ Glaucoma | P☐ C☐ Headaches |
| P☐ C☐ Heart attack or angina | P☐ C☐ Stroke |
| P☐ C☐ Irregular heart rhythm | P☐ C☐ Prostate problem |
| P☐ C☐ Congestive heart failure | P☐ C☐ Breast problem |
| P☐ C☐ Urinary tract infections | P☐ C☐ Asthma |
| P☐ C☐ Emphysema or chronic bronchitis | P☐ C☐ Arthritis |
| P☐ C☐ Pneumonia | P☐ C☐ Hypertension |
| P☐ C☐ Gastroesophageal reflux disease | P☐ C☐ Thyroid problem |
| P☐ C☐ Osteoporosis/Osteopenia | P☐ C☐ High cholesterol |
| P☐ C☐ Depression | P☐ C☐ Addiction Issues |
| P☐ C☐ Anxiety | P☐ C☐ Stomach ulcer |
| P☐ C☐ Kidney Disease, Type: | P☐ C☐ Mental Illness |
| P☐ C☐ Liver Disease, Type: | P☐ C☐ Diabetes |
| P☐ C☐ Bowel/digestive problem | P☐ C☐ Other: |

| Previous Surgical Procedures | |
|---|---|
| Please check if you have had any of the following | |
| Procedure | Year |
| ☐ **Breast Cancer Surgery** | |
| ☐ **Hysterectomy** | |
| ☐ Vascular surgery / stent | |
| ☐ Abdominal aneurysm repair | |
| ☐ Carotid artery surgery | |
| ☐ Gallbladder removed | |
| ☐ Appendix removed | |
| ☐ Tonsillectomy | |
| ☐ Joint replacement<br>☐ Hip ☐ Right ☐ Left<br>☐ Knee ☐ Right ☐ Left | |
| ☐ Spine Surgery ☐ Neck ☐ Back | |
| ☐ Heart surgery | |
| ☐ Pacemaker | |
| ☐ Other: | |

| Social History: |
|---|
| **Marital status**: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Life Partner |
| **Live here year round**? ☐ Yes ☐ No If no, Part time location: ___________________________________________ |
| **Occupation:** **Concerns**: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting |
| **Tobacco use**: ☐ Never ☐ Quit (when)____________ ☐ Current smoker: Packs/day, how many years______________________ |
| **Alcohol use**: ☐ No ☐ Yes If yes how many drinks/how often________________ |
| **Caffeine use:** ☐ No ☐ Yes If yes, ☐ Coffee ☐ Soda ☐ Tea how many drinks/how often________________ |
| **Illicit Drug use** (including marijuana, cocaine, steroids): ☐ Never ☐ Past ☐ Current<br>Describe:_______________________________________________________________________________ |

## Current Health Concerns

Please check problems or conditions that you are CURRENTLY experiencing

| | | | |
|---|---|---|---|
| ☐ Chest pain | ☐ Rectal bleeding | ☐ Forgetfulness | **Breast Specific:**<br>☐ Nipple retraction<br>☐ Breast mass<br>☐ Breast pain<br>☐ Breast discharge |
| ☐ Shortness of breath | ☐ Black/tarry stools | ☐ Loss of vision | |
| ☐ Wheezing | ☐ Weight loss | ☐ Double vision | |
| ☐ Cough | ☐ Weight gain | ☐ Memory loss | |
| ☐ Coughing up blood | ☐ Loss of appetite | ☐ Ringing in ears | |
| ☐ Sore throat | ☐ Difficulty swallowing | ☐ Pain in ears | ☐ Vaginal bleeding/discharge |
| ☐ Nasal congestion | ☐ Diarrhea | ☐ Nose bleeds | ☐ Fever/chills |
| ☐ Irregular heartbeat | ☐ Constipation | ☐ Hoarseness | ☐ Increased thirst |
| ☐ Fast heartbeat | ☐ Painful urination | ☐ Easy bleeding | ☐ Swollen lymph nodes |
| ☐ High blood pressure | ☐ Blood in urine | ☐ Easy bruising | ☐ Seizures |
| ☐ Low blood pressure | ☐ Urine frequency | ☐ Rash | **Gynecology/Obstetrical** |
| ☐ Lightheadedness | ☐ Decrease in urine flow | ☐ Depression/Anxiety | |
| ☐ Dizziness/fainting | ☐ Urine leakage | ☐ Sore that won't heal | Menstrual flow: |
| ☐ Abdominal pain | ☐ Headaches, frequent | ☐ Fatigue/lethargy | ☐ Reg. ☐ Irreg. ☐ Pain/cramps |
| ☐ Heartburn | ☐ Hemorrhoids | ☐ Other (please describe) | Days of flow __ Length of cycle__ |
| ☐ Indigestion | ☐ Loss of strength | | 1st day of last period____________ |
| ☐ Change in bowel habits | ☐ ☐Insomnia | | ☐ Pain or bleeding after sex |
| ☐ Nausea | Pain, weakness, or numbness in | | Number of pregnancies _________ |
| ☐ Vomiting | ☐ Arms ☐ Hips | ☐ Back | Miscarriages__________________ |
| ☐ Vomiting blood | ☐ Legs ☐ Neck | ☐ Shoulders | Birth control method ___________ |
| ☐ Balance problems | ☐ Hands ☐ Feet | ☐ Abdomen | Menopause ☐ Y ☐ N Age: ________ |

## Family History

| Relationship | Living Y/N | Age | Major Medical Problems and/or Cause of Death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Siblings | | | |
| | | | |
| | | | |
| Children | | | |
| | | | |
| | | | |

**Specifically, have any of your relatives had the following conditions:**

| Condition | Relative | Condition | Relative |
|---|---|---|---|
| ☐ Mental illness | | ☐ Chemical dependency | |
| ☐ Diabetes | | ☐ Stroke | |
| ☐ Thyroid Disease | | ☐ Arthritis | |
| ☐ Pituitary Disease | | ☐ Dementia | |
| ☐ Chrohn's/Colitis | | ☐ **Cancer**: ☐ Breast | |
| ☐ Heart Disease < 65 years of age | | ☐ Colon | |
| ☐ Hypertension | | ☐ Ovarian | |

Are there any religious or cultural factors that you would like us to take into account when planning your healthcare?

| Health Maintenance: | | | | | | | |
|---|---|---|---|---|---|---|---|
| Please check whether you have had the following preventive services and enter the year of the service | | | | | | | |
| Immunizations | | | Last Occurrence | Tests | | | Last Occurrence |
| Tetanus vaccine / Tdap | ☐ Yes | ☐ No | | Pap smear/pelvic | ☐ Yes | ☐ No | |
| Pneumonia vaccine | ☐ Yes | ☐ No | | Mammogram | ☐ Yes | ☐ No | |
| Influenza vaccine | ☐ Yes | ☐ No | | Bone Density | ☐ Yes | ☐ No | |
| Shingles vaccine | ☐ Yes | ☐ No | | Colonoscopy | ☐ Yes | ☐ No | |
| Hepatitis ☐ A ☐ B | ☐ Yes | ☐ No | | Prostate test | ☐ Yes | ☐ No | |
| Guardasil (HPV) | ☐ Yes | ☐ No | | Chest X-Ray | ☐ Yes | ☐ No | |

| Hospital Admissions (excluding pregnancies): | | |
|---|---|---|
| Date | Hospital | Reason for admission |
| | | |
| | | |
| | | |
| | | |
| | | |

| Allergies: | |
|---|---|
| Please list any allergies to medications or foods | |
| Name | Symptom/Reaction |
| | |
| | |
| | |
| | |
| | |

| Medications: | | | | | |
|---|---|---|---|---|---|
| Please list any medications that you take including over the counter medications, herbs, and supplements. | | | | | |
| Name | Dose | Freq. | Name | Dose | Freq. |
| | | | | | |
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**Pharmacy**: ___________________________________ **Phone**: _____________________ **Store #**: ______________________

**Location Description**: ___________________________________________________________________________________

| Specialty Providers: | |
|---|---|
| In order that we can best coordinate your care, please list any medical providers you see outside of this practice | |
| **Cardiologist**<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Nephrologist**<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |
| **Ophthalmologist**<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Psychiatrist/Psychologist**<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |
| **Oncologist**<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Allergist**<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |
| **Urologist**<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Gynecologist**<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |
| **Gastroenterologist**<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Pulmonologist**<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |
| **Endocrinologist**<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Podiatrist:** ______________<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |
| **Other:** ______________<br>Name: ______________________<br>Phone: ______________ Last Seen:__________ | **Other:** ______________<br>Name: ______________________<br>Phone: ______________ Last Seen: __________ |

Patient/Guardian Signature:______________________________ Date:______________