FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

Gynecologic Oncology
Health History Questionnaire

Name _____ **Date of Birth** ____/____/____

Current Health Concerns Please check problems or conditions that you are CURRENTLY experiencing				
☐ Lightheadedness	☐ Rectal bleeding	☐ Loss of appetite	☐ Urine frequency	☐ Swollen lymph nodes
☐ Dizziness/fainting	☐ Abdominal pain	☐ Increased thirst	☐ Decrease in urine flow	☐ Seizures
☐ Nausea	☐ Constipation	☐ Weight loss (lbs. _____)	☐ Urine leakage	☐ Depression
☐ Vomiting	☐ Black/tarry stools	☐ Weight gain (lbs. _____)	☐ Sore that won't heal	☐ Anxiety
☐ Vomiting blood	☐ Hemorrhoids	☐ Painful urination	☐ Fatigue/lethargy	
☐ Change in bowel habits	☐ Diarrhea	☐ Blood in urine	☐ Fever/chills	

Gynecology/Obstetrical History		
First day of last period:	Number of pregnancies:	
Menstrual Flow: ☐ Regular ☐ Irregular ☐ Pain ☐ Cramping	Miscarriages: Abortions:	
Days of flow: Time between periods:	Ectopic Pregnancies:	
☐ Pain or bleeding with sex or after sex	Pregnancy Term	Type of Delivery
☐ Vaginal bleeding/discharge		☐ Vaginal ☐ Cesarean
Menopause: ☐ Yes ☐ No Age:		☐ Vaginal ☐ Cesarean
Hormone Replacement Therapy: ☐ Never ☐ Past ☐ Current		☐ Vaginal ☐ Cesarean
Any sexual activity within the last year? ☐ Yes ☐ No		☐ Vaginal ☐ Cesarean
Birth control method:		☐ Vaginal ☐ Cesarean
History of sexually transmitted infections ? ☐ Yes ☐ No	Pregnancy Complications:	

Health Maintenance					
Immunization/Test	**Month**	**Year**	**Tests**	**Month**	**Year**
Gardasil vaccine (HPV)			Colonoscopy/Cologuard		
Mammogram			Bone Density (DEXA)		
Pap Smear/HPV Screening					

Patient/Guardian Signature: _____ Date: _____

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Scanning Category: HHQ/GYN ONC HHQ