Women's Cancer Center

REFERRING DR _____ Name: _____
ADDRESS: _____ Date of Birth: _____ Age: _____
PHONE# _____ Today's Date: _____
FAX # _____

Reason for today's visit: _____

_____

Allergies to medications: _____

GYN HISTORY:

When was your last period? _____ When was your last Pap smaer? _____
Last mammogram? _____ At what age did you have your first period? _____
Do you have a period every month? _____ How many days? _____ Are your period painful? _____
Do you have bleeding between periods? _____ Do you have a history of abnormal Pap smears? _____
Are you currently sexually active? _____ Do you desire more children? _____
Do you use birth control? ( ) Yes or ( ) No If yes, what form? _____
Have you gone through menopause ( ) Yes ( ) No How old were you? _____
Do you take hormones? ( ) yes ( ) no

List any medications you currently take (include herbal vitamins):

Medication	Dose	Frequency

Pharmacy name:_____ Phone number:_____
address or cross streets:_____

*Please continue medication list on back of sheet if necessary.
Do you take Asprin and/or Advil-like medication? _____

Do you have:	Yes	NO
Frequent vaginal infections?		
Frequent bladder infections?		
Sexually transmiitted Disease		
HIV		
Pelvic inflammatory disease or tubal infection		
Loss of urine with coughing		
Blood in urine		
Pain with urination		
Frequent urination		
Pain with intercourse		
Vaginal spotting or bleeding		
Vaginal dryness or itching		

Name: _____

OB HISTORY

Number of pregnancies: ____ (Please list all pregnancies, including those that ended in miscarriage or abortion)
Number of living children: _____ Number of vaginal deliveries _____

MEDICAL/SURGICAL HISTORY	YES	NO
Have you had:		
Blood clots in legs or lungs		
Cancer		
Uterus		
Colon		
Ovaries		
Cervix		
Breast		
Diabetes		
Elevated blood pressure		
Heart disease		
Migraine headaches		
Osteoporsis		
Stroke		
Thyroid		
Kidney disease		
Other		

Has an immediate family member had any of the above? ( ) Yes ( ) No
If yes, what? _____

_____

Bowel Function: Constipation ( ) Yes ( ) No; Diarrhea ( ) Yes ( ) No;
Loss of gas/stool, # of bowel movements per week? _____

List any surgeries you have had previously

SURGERY	DATE

SOCIAL HISTORY

Do you smoke? ( ) yes ( ) no If yes, how much? _____ Drink alcohol ( ) yes ( ) no
If yes, how much? _____
Recreational drugs ( ) yes ( ) no If yes, please list _____

_____

_____