OHC
SPECIALISTS IN CANCER AND BLOOD DISORDERS

GYNECOLOGY/GYN
INITIAL PATIENT SELF-ASSESSMENT

Date: _____

Name: Last: _____ First: _____ MI: _____

PCP: _____ Referring MD: _____

Birth Date: _____ Age: _____ Allergies: _____

Numbers of: Pregnancies: _____ Deliveries: _____ Lost Pregnancies: _____ Living Children: _____

Date of: Last Menstrual Period _____ Last Pap Smear: _____ Result: _____

What problem brings you here today?

_____

List any cancer in your family: _____

_____

List any surgery you have had: _____

_____

Date(s) of last Mammogram: _____ Colonoscopy: _____ Bone Density Test: _____

Have you had tests done recently (biopsy, Pap, ultrasound, scans)? When and Where?

_____

Please check below if you have a history of any of the following:

___ Abnormal Bleeding
___ Asthma, lung/breathing problems
___ Blood clots (leg, lung)
___ Bowel problems
___ Breast lumps
___ Diabetes
___ Disease of the central nervous system
___ Emotional problems
___ Frequent infections
___ Heart disease
___ High blood pressure
___ Irregular PAP Smears
___ Kidney problems
___ Nervous system
___ Open sores/wounds
___ Seizures
___ Stroke
___ Thyroid problems
___ Ulcer disease
___ Unusual lumps
___ Urination problems

Tobacco Use: ❍ Yes ❍ No How much per day? _____ How many years? _____

Alcohol Consumption: ❍ Yes ❍ No ❍ Daily ❍ Weekly ❍ Occasional

Occupation: _____

Who do you live with? _____