WASHINGTON UNIVERISTY SCHOOL OF MEDICINE
DIVISION OF GYNECOLOGIC ONCOLOGY - PATIENT FORM

Name _____ Birth date _____ Age _____ Date ____/____/____

Problems (please state the reasons you want to see your doctor in order of importance to you):

1. _____
2. _____

What doctor referred you to our office? _____Referring doctor's phone number: _____

Have you had any new medical problems or surgical procedures since your last visit? ❑YES ❑NO ❑First Visit
If so, please describe:_____

Medical Conditions (please check all that apply):

❑ Heart Rhythm/Palpitations	❑ Diabetes	❑ Kidney Problems
❑ Heart Failure	❑ HIV/AIDS	❑ Liver Problems
❑ Heart Attack	❑ Psychiatric Problems	❑ Overactive Thyroid
❑ High Blood Pressure	❑ Alzheimer's Disease	❑ Underactive Thyroid
❑ High Cholesterol	❑ Epilepsy	❑ Asthma
❑ Bleeding Disorder	❑ Seizures	❑ Emphysema
❑ Anemia	❑ Stroke	❑ Arthritis
❑ Blood Clots	❑ Headaches	❑ Breast Lump
❑ Embolism	❑ Ulcers	❑ Obstructive Sleep Apnea
❑ Phlebitis	❑ Reflux	❑ Lymphedema

Ever had a cancer? ❑YES ❑NO If yes:

Type: _____ Treatment: _____ Date: _____/_____/_____
Type: _____ Treatment: _____ Date: _____/_____/_____

Operations (list all and year)

_____ _____
_____ _____

Medications (dose and frequency, including supplements and non-prescription medications or attach list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

Medication allergies (drug and reaction if known)

_____ _____ _____

Latex Allergy? ❑YES ❑NO

Obstetric and Gynecologic History/Routine Screening
Pregnancies (Fill in number of each):
Full Term ____ Premature ____ Miscarriage ____ Abortion ____ Number of living children ___ Max fetal weight ____

Last Menstrual Period _____/_____/_____Last Pap Test _____/_____/_____ Ever had an abnormal pap? ❑YES ❑NO

Center for Advanced Medicine
Appointments: 314-362-3181
Fax: 314-362-2893

Missouri Baptist Office
Appointments: 314-996-6075
Fax: 314-996-6074
Version Date 5/13/13

Name _____ Birth date _____ Date ____/____/____

Birth Control Pills ❑YES ❑NO If yes, number of years _____

Ever used Hormone Replacement Therapy ❑YES ❑NO If yes, number of years _____

Ever had a mammogram? ❑YES ❑NO Date: _____/_____/_____Result: ❑NORMAL ❑ABNORMAL

Ever had a colonoscopy? ❑YES ❑NO Date: _____/_____/_____Result:_____

Ever had a bone-density test? ❑YES ❑NO Date: _____/_____/_____Result: ❑NORMAL ❑ABNORMAL

Smoking history: ❑Never ❑Former ❑Current Packs per day _____ How many years _____

Drinking History (Alcohol): ❑Never ❑Former ❑Current Drinks per day _____ How many years? _____

Illegal Drug Use: ❑YES ❑NO How many years? _____ Date of last use _____ Type of drug(s) used_____

Marital Status: ❑Single ❑Married ❑Widowed ❑Separated ❑Divorced ❑Other

Education (circle level completed): High School 9 10 11 12 College 1 2 3 4 Other: _____

Occupation: Yours _____ Spouse/Significant Other _____

Religious Preference _____

Family History

	Age	Alive	Dead	State of Health (if dead, cause of death)
Father		❑	❑	
Mother		❑	❑	
Brother (s)		❑	❑	
		❑	❑	
		❑	❑	
Sister (s)		❑	❑	
		❑	❑	
		❑	❑	
Children		❑	❑	
		❑	❑	
		❑	❑	

Do you have a family history of blood clots, thrombosis and/or embolism? ❑YES ❑NO
If yes, which relatives had clotting problems? _____

Has anyone in your family (including grandparents, aunts, uncles, cousins, others) had:

	Who?	Age of Diagnosis:
❑ Breast Cancer		
❑ Ovarian Cancer		
❑ Uterine Cancer		
❑ Colon Cancer		
❑ Kidney/Bladder Cancer		

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Please circle the number that best describes the level of each symptom below you may be currently experiencing.

Symptom	None	A little	Quite a bit	A lot
Nausea	1	2	3	4
Vomiting	1	2	3	4
Fatigue	1	2	3	4
Pain (where?_____)	1	2	3	4
Change in vision	1	2	3	4
Change in hearing	1	2	3	4
Chest Pain	1	2	3	4
Palpitation	1	2	3	4
Shortness of breath	1	2	3	4
Cough	1	2	3	4
Diarrhea	1	2	3	4
Constipation	1	2	3	4
Blood in bowel movements	1	2	3	4
Pain with urination	1	2	3	4
Blood in urine	1	2	3	4
Lost control of urine	1	2	3	4
Abdominal pain	1	2	3	4
Abdominal bloating	1	2	3	4
Skin rash	1	2	3	4
Numbness (where?_____)	1	2	3	4
Tingling of hands or feet	1	2	3	4
Headaches	1	2	3	4
Depression	1	2	3	4
Mood Changes	1	2	3	4
Vaginal bleeding	1	2	3	4
Easy bruising/bleeding	1	2	3	4
Hot flashes	1	2	3	4
Hair Loss	1	2	3	4

❑**All other systems negative**

Please describe any symptom you want us to know more about:

_____

List other physicians you have seen in the last two years and why:

_____

_____

Preferred Pharmacy Name: _____ Preferred Pharmacy Phone:_____

Patient Home Phone:_____ Patient Cell Phone: _____

Emergency Contact Name, Relationship and Phone Number: _____

_____ _____

Patient's Signature and Date **Physician's Signature and Date**

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