

Michigan Center for Gynecologic Cancer
New Patient Intake Form

Name _____
Social Security No. _____
Date of Birth _____
Home Phone _____
Work Phone _____
Cell Phone _____
Primary Care Doctor _____

Referring Doctor _____
Do you have prescription coverage?
YES or NO

If yes, how much do you pay for
each Rx? _____

Why are you here today?

Past Medical History:

Do you currently have or ever had one of the following:

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypercholesterolemia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> hypertryglyceridemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Bleeding Tendencies | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Cancer: (see below) | <input type="checkbox"/> Mental illness/Depression/Anxiety |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Gastro-esophageal reflux disease
(GERD) |
| <input type="checkbox"/> Diabetes, how long? | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Skin lesions/rash |
| <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Influenza | |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sexually-transmitted diseases | |
| <input type="checkbox"/> Seizures | |

Prior Cancer Treatment

Date Diagnosis Treatment (surgery, chemotherapy, radiation, other)

Past Surgical History:

Year	Operation	Surgeon/Hospital

Gyn History

Total Pregnancies ___ Miscarriage/Abortions ___
 Full Term ___ Ectopic ___
 Preterm ___ Live Births ___

Age at first pregnancy ___
 Type of birth control (circle)
 Birth control pills Depo-provera IUD Condoms
 Tubal ligation – year done ___ Hysterectomy None

Do you still have periods? Yes or No
 If yes, does your cycle come once a month? Yes or No
 When was your last menstrual cycle? _____
 Have you ever used hormone replacement therapy (creams/pills/patches)? Yes or No
 If yes, please list drug and dates used _____

Do you have or have you had in the past one or more of the following
 Frequent vaginal discharge ___ Break through bleeding ___
 Bleeding during intercourse ___ Pain during intercourse ___
 Test positive for HIV/AIDS ___ Vaginal dryness ___
 DES exposure ___

Have you ever had an abnormal pap test? Yes or No
 If yes, please list the date and outcome

Have you ever had a colonoscopy? Yes or No
 If yes, please list the date, reason for exam and outcome

Have you ever had a mammogram? Yes or No
 If yes, please list the most recent and any abnormal results (date, outcome)

Family History

Cancer (relative, type, age of onset) High Blood Pressure, Heart Disease, Diabetes, other

Social History

Marital Status Single Married Divorced Widowed

Occupation _____

Alcohol Use Never Rare Weekly Daily

Smoking Currently Yes No
 Past Yes No Year Quit

Cocaine use Current Yes No
 Past Yes No Year Quit

IV Drug use Current Yes No
 Past Yes No Year Quit

Other drugs Yes No Please specify _____

Current Medications

Drug Dose How often/When

Allergies

Drug/Food Type of Reaction
