

**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?**

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**Past Medical History:**

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

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|--|---|
| <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<br>(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)
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**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

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**Allergies**

Drug/Food Type of Reaction

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