



GYNECOLOGIC ONCOLOGY

INTAKE FORM

Name _____

Date of Birth _____ Today's Date _____ Email Address: _____
Referring Physician Name & Address _____

Primary Care Physician (if different) _____

What is the reason for your visit today?

Is this a routine

visit? Yes ___ No ___

Describe the problem

When did it start? _____ What does it feel like/what are the symptoms?

How severe are the symptoms? (1-10) _____ Where are they located?

_____ What makes it better or worse?

_____ Have you been taking medications for this problem? _____

Have there been previous episodes? _____

Did you seek previous medical care of this problem? _____

Do you have any allergies to medications or other substances? Yes ___ No ___

If yes, please list allergies and reactions (rash, hives, throat swelling, anaphylaxis)

Please list **ALL** of your current medications below (use back of page if you need more room):

MEDICATION NAME	DOSAGE	WHEN DO YOU TAKE IT?	APPROXIMATE START DATE

OB/GYN HISTORY:

Number of pregnancies _____ Live births _____ Vaginal Deliveries _____ Cesarean Sections _____ Miscarriages _____ Tubal Pregnancies _____ Terminations _____ Living Children _____

When was your last menstrual period? _____ Age of first period _____

How frequently do you have your period? _____ If irregular, describe frequency _____

Is your flow heavy? _____ How many days do you bleed? _____ Do you stain/bleed between regular periods? _____ Do you have pain with periods? _____

If so, describe: _____

If your periods have stopped do you have any symptoms associated with menopause? Yes ___ No ___

If yes, describe _____

Are you currently sexually active? Yes ___ No ___

Do you have any problems associated with sexual relations? Yes ___ No ___

If yes, Describe:

When was your last PAP Smear? _____ Have you ever had an abnormal PAP? Yes ___ No ___ If yes, When? _____

If you were told you had HPV describe how you were treated: _____

Have you ever been treated for for a sexually transmitted disease?

If yes,
explain: _____

Have you ever been tested for HIV? Yes ___ No ___ When? _____

MEDICAL HISTORY:

Have you ever had (been diagnosed or treated for) any of the following (if yes, describe)

CONDITION	YES	NO	DESCRIBE
HEART DISORDER			
STOMACH/INTESTINAL DISORDER			
SKIN DISORDER			
CLOTTING DISORDER			
EYE DISORDER			
PSYCHIATRIC DISORDER			
URINARY/KIDNEY DISORDER			
LIVER DISORDER/ HEPATITIS			
ORTHOPEDIC DISORDER			
CHOLESTEROL DISORDER			
NEUROLOGIC DISORDER			
DIABETES			
HIGH BLOOD PRESSURE			
ARTHRITIS			
FIBROIDS			
ENDOMETRIOSIS			
CANCER			
THYROID DISORDER			
LUNG DISORDER			

OTHER SURGICAL HISTORY:

List any surgeries you have had and the approximate date:

Appendectomy _____ Laparoscopies _____

Gallbladder _____ Abdominal Surgeries _____

Tubal Ligation _____ Hysterectomy _____

Breast Surgeries _____ Ovaries Removed Yes ___ No ___

Others: _____

Have you had a blood transfusion? Yes ___ No ___ If yes, when? _____

HEALTH MAINTENANCE/DIAGNOSTIC HISTORY :

Last Mammogram _____ Normal ___ Abnormal ___

Last Bone Density _____ Normal ___ Abnormal ___

Last Cholesterol _____ Normal ___ Abnormal ___

Last Colonoscopy _____ Normal ___ Abnormal ___

FAMILY HISTORY:

Please indicate any major conditions/illnesses that your family members have had Condition & Description Living If deceased, what age?

Mother _____

Father _____

Sibling _____

CONDITION	YES	NO	WHICH RELATIVE
Breast cancer			
Colon cancer			
Uterine cancer			
Ovarian cancer			
Other cancer			

SOCIAL HISTORY:

Occupation: _____ Who do you live with at home?
_____ Marital Status: _____

Do you exercise regularly? Yes ___ No ___

Do you have a healthcare proxy? Yes ___ No ___

Who can be contacted with or given your health information?

NAME	RELATIONSHIP	CONTACT NUMBER

Tobacco:

Currently? Yes ___ No ___ Previously? Yes ___ No ___ Yrs Smoked _____ Packs/Day _____

Are/Were you exposed to 2nd hand smoke at home or work? Yes ___ No ___

If yes, Explain: _____

Other substances:

Alcohol? Yes ___ No ___ Recreational drugs? Yes ___ No ___

Describe Use _____

REVIEW OF SYSTEMS:

		YES	NO		YES	NO
General	Fevers			Chills		
	Sweats			Weight loss		
	Feeling tired			Feeling sick		
	Appetite loss			NONE OF THE ABOVE		
Eyes	Double vision			Blurring		
	Discharge			Pain		
	Light sensitivity			NONE OF THE ABOVE		
Ear/Nose Throat	Ringling in ears			Nosebleeds		
	Decreased hearing			Hoarseness		
	Earache			NONE OF THE ABOVE		
Heart	Shortness of breath			Swollen feet		
	Racing heart			Near fainting		
	Chest pain			Weight gain		
	Lightheadedness			NONE OF THE ABOVE		
Lungs	Coughing up blood			Phlegm		
	Wheezing			Shortness of breath		
				NONE OF THE ABOVE		
Gastro Intestinal	Loss of appetite			Nausea		
	Diarrhea			Vomiting		
	Constipation			Black stool		
	Blood in stool			Hemorrhoids		
	Change in bowel habits			Bloating		
	Gas			Abdominal pain		
			NONE OF THE ABOVE			
Genito Urinary	Frequent urination			Blood in urine		
	CONDITION	YES	NO	CONDITION	YES	NO
	Night time urination			Back pain		
	Painful urination			Pelvic pain		
	Abnormal vaginal bleeding			Urinary urgency		
			NONE OF THE ABOVE			
Musculo Skeletal	Joint pain			Stiffness		
	Arthritis			Muscle aches		
	Muscle weakness			NONE OF THE ABOVE		
Skin	Rash			Itching		
	Suspicious lesion			Nail changes		
	Hair changes			Color change		
	Open wounds			NONE OF THE ABOVE		
Neuro	Headaches			Poor balance		
	Numbness			Tingling		
	Seizures			Tremors		
	Falling down			Vertigo		

	Excessive sleepiness			Forgetfulness		
				NONE OF THE ABOVE		
Psych	Thoughts of suicide			Depression		
	Thoughts of violence			Anxiety		
	Frightening sounds or visions			NONE OF THE ABOVE		
Endocrine	Heat intolerance			Thirst		
	Weight change			NONE OF THE ABOVE		
Heme Lymph	Bleeding			Fevers		
	Easy bruising			NONE OF THE ABOVE		

Thank you for taking the time to complete this questionnaire!

 **New York-Presbyterian**
Brooklyn Methodist Hospital

NYP MEDICAL GROUP BROOKLYN

DEMOGRAPHIC SHEET

Date: _____

PATIENT INFORMATION

Patient Name (Last, First) _____

Home Address _____ Apt # _____

City/State _____ Zip Code _____

Age _____ Religion _____ Race _____

Cell Phone _____ Home Phone _____

D.O.B. _____ Marital Status _____

Email _____

INSURANCE INFORMATION

Primary Insurance Name _____

ID Number _____ Group Number _____

Policyholder's Name _____ D.O.B. _____

Secondary Insurance Name _____

ID Number _____ Group Number _____

Policyholder's Name _____ D.O.B. _____

EMERGENCY CONTACT INFORMATION AND HIPAA REPRESENTATIVE

Emergency Contact Name _____

Relationship to Patient _____

Phone No. _____ Secondary Phone No. _____

REFERRING DOCTOR INFORMATION

Referring Doctor _____

Phone No. _____ Fax _____

PCP Name _____

Phone No. _____ Fax _____

Pharmacy Name _____

Phone No. _____