FLORIDA GYNECOLOGIC ONCOLOGY

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NEW PATIENT CONSULTATION

Name: _____ Age: _____ Date: _____

Patient E-mail Address: _____

Names of your doctor(s): _____

Why did you come to see the doctor today? _____

_____

Pharmacy Name: _____ Phone Number: _____

Do **you** have, or have you ever had, any of the following medical problems (please check all that apply to you)?

❑ Diabetes	❑ Tuberculosis	❑ Allergies	❑ Breast Disease
❑ Heart Disease	❑ Thyroid Dysfunction	❑ Hypertension	❑ Lung Disease
❑ Kidney Disease	❑ Epilepsy / Seizures	❑ Blood Clots	❑ Bleeding Problems
❑ Liver Disease	❑ Phlebitis	❑ Cancer	❑ Other: _____

In case of radical/surgical emergency, do you accept blood transfusion? . . . . . ❑ Yes ❑ No

Have you ever been hospitalized? . . . . . ❑ Yes ❑ No

If yes, when, where and what for? _____

_____

Have you ever had surgery? . . . . . ❑ Yes ❑ No

If yes, what for, when and where? _____

_____

List **all** current medications: _____

_____

_____

Are you allergic to any medications? . . . . . ❑ Yes ❑ No

Please list and explain reaction: _____

Are you having menstrual periods? . . . . . ❑ Yes ❑ No

If yes, date of last period: _____ Are your menstrual periods: ❑ Regular ❑ Moderate ❑ Heavy ❑ Irregular

If you are not having menstrual periods, when did they stop? Year: _____

Have you been sexually active in the past? . . . . . ❑ Yes ❑ No

Are you currently sexually active? . . . . . ❑ Yes ❑ No

How many times have you been pregnant? _____ How many children do you have? _____

Does your **family** have a history of (please check all that apply to your family):

- ❑ Diabetes
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Tuberculosis
- ❑ Thyroid Dysfunction
- ❑ Epilepsy / Seizures
- ❑ Phlebitis
- ❑ Allergies
- ❑ Hypertension
- ❑ Blood Clots
- ❑ Cancer
- ❑ Breast Disease
- ❑ Lung Disease
- ❑ Bleeding Problems
- ❑ Other: _____

Do you use: ❑ Tobacco (how much): _____ ❑ Alcohol: _____ ❑ Narcotics: _____

Have you been tested for HIV? . . . . . ❑ Yes ❑ No

If yes, date and result: _____

REVIEW OF SYSTEMS (please check all that apply to you)

Skin	❑ Normal	❑ Rash	❑ Ulcers	
Neurological	❑ Normal	❑ Seizures	❑ Neuropathy	❑ Syncope/Pass Out
Psychiatric	❑ Normal	❑ Depression		
Endocrine	❑ Normal	❑ Diabetes	❑ Thyroid Disease	❑ Hot Flashes
Urinary	❑ Normal	❑ Blood in Urine	❑ Pain on Urination	
		❑ Leakage of Urine	❑ Urgency to Void	
Genital	❑ Normal	❑ Abnormal Bleeding	❑ Vaginal Discharge	❑ Breast Pain
Sex Function	❑ Normal	❑ Painful Intercourse	❑ Bleeding after Intercourse	❑ Lack of Desire
Hematology	❑ Normal	❑ Easy Bruising	❑ Spontaneous Bleeding	
		❑ Enlarged Lymph Nodes		
Allergy	❑ Normal	❑ Seasonal Allergies	❑ Drug Allergies	
General	❑ Normal	❑ Weight Loss	❑ Fatigue	
Eyes	❑ Normal	❑ Change in Vision		
Ears/Mouth	❑ Normal	❑ Problems Hearing	❑ Ulcers	❑ Sore Throat
Cardiovascular	❑ Normal	❑ Chest Pain	❑ Shortness of Breath with Exercise	
		❑ Shortness of Breath in Bed		
Respiratory	❑ Normal	❑ Shortness of Breath	❑ Wheezing	
		❑ Respiratory Infection (cold)		
Gastrointestinal	❑ Normal	❑ Nausea/Vomiting	❑ Diarrhea	❑ Blood Stools
Musculoskeletal	❑ Normal	❑ Muscle Weakness	❑ Arthritis	

HealthCare Screening Tests: (please list date and result of most recent test)

Pap Test: _____ Mammogram: _____ Colonoscopy: _____

Signature: _____ Date: _____