**GYNECOLOGIC ONCOLOGY QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring MD/Primary care (Who should be send reports to): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***If YOU have been diagnosed with any of these CANCERS, circle yes and indicate the age you were diagnosed:***

Ovarian Yes Age diagnosed:\_\_\_\_\_\_

Breast Yes Age diagnosed:\_\_\_\_\_\_

Pancreatic Yes Age diagnosed:\_\_\_\_\_\_

Melanoma Yes Age diagnosed:\_\_\_\_\_\_

Endometrial/Uterine Yes Age diagnosed:\_\_\_\_\_\_

Colon/Rectal Yes Age diagnosed:\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes Age diagnosed:\_\_\_\_\_\_

***Have YOU been diagnosed with any cancer syndromes?***

BRCA 1 or 2 Yes Age diagnosed:\_\_\_\_\_\_

Lynch syndrome Yes Age diagnosed:\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age diagnosed:\_\_\_\_\_\_

***Have you ever had any of the following surgeries? If yes, what year?***

|  |  |
| --- | --- |
| * Hysterectomy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Fibroids removed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Tubal ligation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Removal of intestines\_\_\_\_\_\_\_\_\_\_\_ * Appendix removed\_\_\_\_\_\_\_\_\_\_\_\_\_ * C-section\_\_\_\_\_ if yes,   How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | * D&C\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Liver surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Gallbladder removed\_\_\_\_\_\_\_\_\_\_\_\_ * Ovarian cyst removed\_\_\_\_\_\_\_\_\_\_\_\_ * Ovary removed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Tonsils or adenoids removed\_\_\_\_\_\_ * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Family history**

Father: ⃝ Alive Age\_\_\_\_\_\_ State of Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health problems ⃝ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Deceased Age at death\_\_\_\_\_

Mother: ⃝ Alive Age\_\_\_\_\_\_ State of Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health problems ⃝ Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⃝ Deceased Age at death\_\_\_\_\_

Siblings/Children: Circle Alive Age Deceased Age State of Health

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Brother or Sister  Brother or Sister  Brother or Sister  Son or Daughter  Son or Daughter | Yes/No  Yes/No  Yes/No  Yes/No  Yes/No | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | Yes/No  Yes/No  Yes/No  Yes/No  Yes/No | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Do you have any Jewish Ancestry (Central or Eastern European)? \_\_\_\_ Yes \_\_\_\_ No**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OB History**

How many times have you been pregnant? \_\_\_\_\_\_\_

What was the outcome of each pregnancy: full term deliveries\_\_\_\_\_\_ Preterm deliveries\_\_\_\_\_\_\_ # of C-sections \_\_\_\_\_\_\_\_ # of vaginal deliveries\_\_\_\_\_\_\_\_\_\_ Miscarriages/abortions\_\_\_\_\_\_\_

**GYN History *Have you ever had the following:***

|  |  |
| --- | --- |
| Cervical surgery  Hysterectomy  Hysteroscopy  Laparotomy for cancer  Ovarian surgery  Vaginal surgery  Vulvar surgery | Yes/No  Yes/No  Yes/No  Yes/No  Yes/No  Yes/No  Yes/No |

What was the first day of your last period?\_\_\_\_\_\_\_\_\_

What is the interval between periods?\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any bleeding in between periods?\_\_\_\_\_

Have you undergone menopause? \_\_\_\_Yes \_\_\_\_No

If yes, what age was menopause?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed with a sexually transmitted infection? If yes, please provide details:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last pap smear?\_\_\_\_\_\_\_\_\_\_\_\_ What was the result?\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any abnormal pap smears in the past? \_\_\_\_Yes \_\_\_\_No

If yes, what was done for that?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use contraceptives? \_\_\_\_Yes \_\_\_\_No If yes, what do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of symptoms**

Are you currently having or have you recently had (check box)

**General ENT Neck Lung**

|  |  |  |  |
| --- | --- | --- | --- |
| * Increased weight * Decreased weight * Weakness * Bleeding * Bruising * Fever * Chills * Infection * Injury | * Vision changes * Hearing changes * Ringing in ears * Nose bleeds * Unusual sneezing * Sore throat * Swallowing difficulty * Ear pain * Facial pain | * Neck pain * Cough * Cough with mucus * Wheezing * Shortness of breath   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Heart**   * Palpitations * Chest pain * Shortness of breath upon exertion | * Cough with mucus * Cough without mucus * Wheezing * Shortness of breath * Shortness of breath while lying flat * Coughing up blood   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Skin**   * Rash * Dry skin * Sores that don’t heal * Skin spots that have changed |

**Bone and Joint Abdomen Genito-urinary Neurological**

|  |  |  |  |
| --- | --- | --- | --- |
| * Joint pain * Joint stiffness * Back pain * Neck pain * Muscle cramps * Muscle aches * Have you had a broken bone? * Have you been diagnosed with osteoporosis? | * Pain * Belching * Nausea * Vomiting * Diarrhea * Constipation * Blood in stools * Excessive gas | * Blood in urine * Lack of bladder control * Painful urination   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Breast**   * Breast lump * Nipple discharge   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Psychological**   * Anxiety * Depression | * Memory loss * Disorientation * Syncope (faintness) * Double vision * Vertigo (spinning sensation) * Numbness/tingling * Headache |