THIS IS AN INFORMATIONAL FORM AND IS NOT A PERMANENT PART OF THE MEDICAL RECORD

WATSON CLINIC LLP

Quality Healthcare for Every Generation

GYN/ONC QUESTIONNAIRE

Place Patient Label Here

Name_____ Age_____ Date_____

Primary Doctor_____

Doctor who requested today's visit _____

PLEASE LEAVE BLANK FOR OFFICE STAFF

When was your last menstrual period? _____

How many times have you been pregnant? _____ How many births? _____

How many births were by cesarean section? _____ How many were vaginal? _____

When was your last pap smear? _____ Results? _____

Have you ever had an abnormal pap? _____

Do you have any of the following medical conditions? If yes, please check.

- ☐ Heart disease
- ☐ History of Heart Attack
- ☐ Congestive-Heart Failure
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Difficulty Breathing
- ☐ Lung Disease
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Ulcers or Heartburn
- ☐ Kidney Disease
- ☐ Bleeding Disorders
- ☐ Stroke or "mini stroke"
- ☐ History of Blood Clots
- ☐ History of Blood Transfusion
- ☐ Breast Disease
- ☐ Lupus
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ High Cholesterol
- ☐ Other_____

Will you accept blood transfusion or blood products (e.g. platelets) in the setting of a medical emergency where such transfusion is recommended by your doctor? _____

Are you allergic to any medications or latex? If yes, please list and describe the reaction. _____

_____

What medicines do you take? (include prescription, non-prescription, doses and how often) _____

_____

_____

_____

_____

_____

Have you required hospitalization that was not for surgery or related to childbirth? _____

If yes, please explain: _____

_____

_____

Please list your past surgeries:

DATE	SURGERY	REASON

Have you ever smoked? _____ If yes, how much, how long, year quit? _____

Do you drink alcohol? _____ If yes, how much, how often? _____

Do you use any illegal drugs? _____ If yes, how much, how often? _____

Are you employed? _____ If so, where? _____

Are you single, married, divorced, or widowed? _____

In what city do you live? _____

Who else is living in the home? _____

Does anyone in your family have or has ever had any of the following? (deceased or alive)

Breast Cancer _____

Ovarian Cancer _____

Colon Cancer _____

Uterine Cancer _____

Bleeding Disorders _____

Please check any of the following problems you are **CURRENTLY** having:

- ☐ Fevers or chills
- ☐ Losing weight
- ☐ Trouble with vision
- ☐ Trouble with hearing
- ☐ Ringing in your ears
- ☐ Fatigue
- ☐ Chest pain
- ☐ Racing heart
- ☐ Trouble breathing
- ☐ Cough
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Heartburn/Indigestion
- ☐ Leaking urine
- ☐ Burning with urination
- ☐ Vaginal bleeding
- ☐ Unusual vaginal discharge
- ☐ Unusual joint or muscle aches
- ☐ Hot flashes
- ☐ Swollen lymph glands
- ☐ Easy bruising
- ☐ Numbness in hands or feet
- ☐ Depression
- ☐ Trouble sleeping
- ☐ Rash

When was your last mammogram? _____ Results? _____

When was your last colonoscopy? _____ Results? _____