

**BAY AREA GYNECOLOGY ONCOLOGY
PATIENT HEALTH ASSESSMENT**

Patient Name:			Date:
Age:	Height:	Weight:	Referring Physician:

MEDICATIONS

ALLERGIES

Name	Dose	Reason	Name	Reaction

G.P. Internist: _____
 Cardiologist: _____
 Pharmacy Name: _____

Gynecologist: _____
 Other Specialist: _____
 Pharmacy Telephone: _____

MEDICAL HISTORY: (Circle Y for yes and N for no)

Neuro

Y N Stroke
 Y N Seizures
 Y N Migraines
 Y N Headaches
 Y N Fainting
 Y N Weakness
 Y N Numbness

Heart

Y N Heart Attack
 Y N Irregular heart rate
 Y N High blood pressure
 Y N Rheumatic fever
 Y N Heart Murmur/MVP
 Y N Pacemaker/
 Defibrillator
 Y N Angina, chest pain
 Y N Short of breath
 (SOB)
 Y N SOB w/exertion
 Y N Swelling feet/ankle
 Last EKG Date _____

Lung

Y N Asthma
 Y N Steroid use
 Date last used _____
 Y N Emphysema
 Y N Bronchitis
 Y N Pneumonia
 Y N Blood Clot
 Y N Sleep apnea/snoring
 Y N Smoke Cigarettes
 _____ # or packs/day

Endocrine

Y N Hypothyroid
 Y N Hyperthyroid
 Y N Diabetes

 Y N Steroid use

Skin

Y N Skin disease _____

Gynecologic

Last Menstrual Period

 Last Pap Test

 Date Normal Abnormal

 Hormone Replacement

 Name Date

 Menopause Onset
 _____ Year

For office use:

Date: _____ Weight: _____ B/P: _____ P: _____ Temp: _____

Reproductive

Y N Possibility of being Pregnant now
___ # of pregnancies
___ # vaginal delivery
___ # C-section
___ Living children
___ Hope to have more Children

Gastrointestinal

Y N Hepatitis
Y N Ulcers
Y N Intestinal disease
Y N Abdominal pain
Y N Change in bowel habits
Y N Blood in stool
Y N Constipation
Y N Diarrhea
Y N Ulcerative colitis
Y N Regional enteritis

Kidney Disease

Y N Kidney stones
Y N Other kidney disease
Y N Dialysis
Y N Painful urination
Y N Blood in urine
Y N Urinary Incontinence
___ When coughing, laughing, sneezing
___ Urinary Urgency/frequency

Breast Disease

Last Breast Exam _____
Last Mammogram
Date _____
Normal _____
Abnormal _____
Y N History of breast cancer?

Hematologic Disease

Y N Bleeding Disorder
Y N Easy bruising
Y N Frequent nosebleeds
Y N Previous blood Transfusion

Muscle/Joint Disorders

Y N Arthritis
Y N Paralysis
Y N Myasthenia gravis
Y N Malignant hyperthermia
Y N Leg pain
Y N Back Pain
Y N Muscle weakness

Eye Disease

Y N Glaucoma
Y N Cataracts
Y N Macular Degeneration

Previous Chemo

Cancer type treated _____
Dates _____ Medications _____

Previous Radiation Therapy

Date _____
Site Treated _____
Location of Radiation Ctr. _____

Drugs

Y N Do you use recreational drugs?
Types: _____

Alcohol

Y N Do you drink alcohol?
___ # of drinks/day

PREVIOUS SURGERIES

Procedure	Year	Type of Anesthesia	Complications

Do you use aspirin or aspirin containing compounds: Yes No Type: _____
Do you use blood thinners (Heparin, Coumadin, etc.)? Yes No Type: _____
Do you take supplements, herbs, or other 'alternative' treatments ? Yes No Type: _____

PERSONAL INFORMATION

Please rate your level of activity: Very active Moderately active Not active

Is your level of activity related to health limitations? Yes No

Level of Education: High School College Post Graduate

Please note any familial or hereditary illnesses:

Y N Have you or your immediate family had unusual reactions, problems or complications associated with anesthesia?
Describe: _____

Y N Has anyone in your family had cancer?
How are they related and what type or cancer ? _____

SOCIAL HISTORY

Marital status: Single / Married / Divorced / Widowed

Do you live with anyone? Y N If yes, who? _____

What type of work do you do? _____