**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 SisterBrother or SisterBrother or SisterSon or DaughterSon or Daughter | Yes/NoYes/NoYes/NoYes/NoYes/No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes/NoYes/NoYes/NoYes/NoYes/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 surgeryHysterectomyHysteroscopyLaparotomy for cancerOvarian surgeryVaginal surgeryVulvar surgery | Yes/NoYes/NoYes/NoYes/NoYes/NoYes/NoYes/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
 |