UR MEDICINE | WILMOT CANCER INSTITUTE

Division of Gynecologic Oncology

Richard G. Moore, MD, FACS, FACOG, Division Chief
Cynthia Angel, MD, FACOG
Brent DuBeshter, MD, FACOG
Cici Liu, MD
Sajeena Geevarghese, MD, FACOG
Rachael Turner, MD, PhD
Pebble Kranz, MD, FECSM
Negar Khazan, PhD
Kyu Kwang Kim, PhD
Rakesh Singh, PhD
Marlise Combe, MS
Lauren Mahon, NP
Janelle Hennard, NP
Sarah Rossi, NP
Hadassah Bennett, NP
Karen Kugel, BSN, RN, OCN
Kim Altobelli, RN, OCN
Gina Smith-Donke, BSN, RN, OCN
Melissa Mitchell, BSN, RN, OCN
Dawn Torpey, BSN, RN
Kimberly Fess, BSN, RN, OCN

Clinical Research Group:
Laura Mitchell
Mary Sears
Barbara Kavinsky

Office Manager: Sherri Krohn

University of Rochester Medical Center
Wilmot Cancer Institute
125 Lattimore Road, Suite 258
Rochester, NY 14620
Phone: (585) 442-8020
Fax: (585) 442-8039

Patient Name: _____DOB: _____ Date: _____

Welcome to our practice. Please answer the following questions in the appropriate spaces below. Use a question mark (?) if you are unsure of an answer. Please answer all questions as completely as possible. Please complete both front and back of each page.

What is your understanding of why you are here?

_____

_____

Allergies:

Yes☐ No☐ Do you know of anything you are allergic to or gives you a rash?

If so, please list:

Drug/Food	Reaction

Medications:

Yes☐ No☐ Do you take any medications regularly? Please include prescriptions as well as over the counter medications, vitamins, and supplements.

Medications	Dose	How often

Review of Systems: Are you currently experiencing any of the following?

Yes☐ No☐ Pain or incontinence with urination
Yes☐ No☐ Constipation or Diarrhea
Yes☐ No☐ Weight gain or weight loss
Yes☐ No☐ Swelling of hands or feet
Yes☐ No☐ Problems with eyesight or hearing
Yes☐ No☐ Pain_____ Location_____: Please rate on a scale from 1-10 with 10 being the worst pain you have experienced: _____

Screening:
Yes☐ No☐ Have you had a mammogram? When? _____ Results? _____
Yes☐ No☐ Have you had a colonoscopy? When? _____ Results? _____
Yes☐ No☐ Have you had a pap smear? When? _____ Results? _____

Surgical History:
Yes☐ No☐ Have you had any surgeries or hospitalizations? Please list with approximate year.

Gynecologic History:
Yes☐ No☐ Have you ever been pregnant? Number of pregnancies? ____ Number of births? ____
Yes☐ No☐ Are you currently sexually active? Method of birth control? _____
Yes☐ No☐ Have you used birth control pills or hormones? For how long? _____
Yes☐ No☐ Have you gone through menopause? Date of last menstrual period? _____

Social History:
Yes☐ No☐ Do you drink alcohol? How often? _____
Yes☐ No☐ Do you smoke? Daily_____ Occasionally _____ Former smoker_____
Yes☐ No☐ Do you use recreational drugs?
Marital Status: Married☐ Single ☐ Widowed☐ Divorced☐ Life Partner☐
Occupation: _____

Medical/ Family History: Please check "Self" if you have had one of the following problems, check "Family" and indicate which member of your family has/had this condition.

Condition:	None	Self	Family (please indicate relation of relative)
Arthritis	☐	☐	
Alzheimer's disease	☐	☐	
Asthma	☐	☐	
Blood clots	☐	☐	
Diabetes	☐	☐	
Hypertension	☐	☐	
Heart disease	☐	☐	
HIV	☐	☐	
Hepatitis	☐	☐	
Kidney disease	☐	☐	
Stroke	☐	☐	
Other	☐	☐	

Cancer History:

Yes☐ No☐ Do you have a history of cancer?

If yes, please complete the table below for your past cancer, radiation treatment, or chemotherapy that you may have had.

Past cancer type	Age of first Diagnosis	Did you receive chemotherapy?			Did you have surgery?			Did you have radiation therapy?			Did you have another treatment type?		
		Yes	Age	No	Yes	Age	No	Yes	Age	No	Yes (List Type)	Age	No
		☐		☐	☐		☐	☐		☐			☐
		☐		☐	☐		☐	☐		☐			☐
		☐		☐	☐		☐	☐		☐			☐
		☐		☐	☐		☐	☐		☐			☐
		☐		☐	☐		☐	☐		☐			☐

Yes____ No____ Do you have any family history of cancer?

If yes please complete the table below for family history of cancer. Please provider as much detail as you can about any additional relatives who have had cancer on your paternal (father's side of the family) and maternal (mother's side of the family) relatives. Remember to include those who are no longer living.

	Been diagnosed with cancer?		If YES:	
	Yes	No	Type of Cancer	Age of onset
Mother	☐	☐		
Father	☐	☐		
Sons	☐	☐		
Daughters	☐	☐		
Brothers	☐	☐		
Sisters	☐	☐		
PATERNAL (Father's side)				
Cousins	☐	☐		
Grandsons	☐	☐		
Granddaughters	☐	☐		
Grandfather	☐	☐		
Grandmother	☐	☐		
Uncles	☐	☐		
Aunts	☐	☐		
Half-brothers	☐	☐		
Half-sisters	☐	☐		
Other relatives	☐	☐		
MATERNAL (Mother's side)				
Cousins	☐	☐		
Grandsons	☐	☐		
Granddaughters	☐	☐		
Grandfather	☐	☐		
Grandmother	☐	☐		
Uncles	☐	☐		
Aunts	☐	☐		
Half-brothers	☐	☐		
Half-sisters	☐	☐		
Other relatives	☐	☐		

Yes☐ No☐ Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?

Advanced Directives:
Yes☐ No☐ Have you completed a Health care proxy or Advanced directive?
Yes☐ No☐ If not would you like information regarding appointing a Health care proxy?

Please list other healthcare providers who should receive information regarding your care:

_____

_____

_____

_____

To the best of my knowledge, the information provided on this form is accurate and complete.

Signature of Patient or Representative: _____ Date: _____

Date reviewed: _____ by: _____

AMBULATORY CARE INVOLVEMENT IN CARE DISCUSSION FORM

(Reference HIPAA Policy 0P23.2)

Patient Name: _____ Date:_____

Gynecologic Oncology may discuss protected health information, including lab/test results with the following people:

Name	Relationship	Phone Number

NEXT OF KIN INFORMATION
Name:_____ Relationship_____
Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Alternate Number:_____

COMMUNICATION REQUESTS:

Phone me using the following (#)_____

Y ☐ N ☐ May phone at work (#)_____

Employer Name:_____

☐ ☐ May leave messages on answering machine

☐ ☐ May send message via MyChart

This will remain in effect until notified differently by the patient.

Patient Signature_____ Date:_____