

Date _____

CHAPERONE: Accepted ____ Declined ____

NAME: _____ Place Label Here

AGE: _____

Reason for Visit: _____

Primary Care Provider: _____ City _____

Referring Care Provider: _____ City _____

Other Involved Providers: _____ City _____

_____ City _____

Review of Active Medical Problems

Medical History (Please list any present or past medical problems you may have)

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Surgical History (Please include all gynecologic surgeries, i.e. hysterectomy, C-section, etc)

Year	Type of Operation
Year	Type of Operation
Year	Type of Operation
Year	Type of Operation

Problems with anesthesia? Yes No

Social History

Smoker: Yes No _____ Packs/day	Have you smoked in the past? Yes No Packs/day _____ How long ago? _____
Alcohol Drinks? Yes No #drinks/day: _____	Recreational drug use? Yes No
Do you live alone? Yes No Do you require assisted living? Yes No Do you drive? Yes No	

Family History (e.g. hypertension, diabetes, heart attack, clotting disorders, history of bleeding)

	Age if living	Age at death	Medical Problems	Cause of Death
Mother				
Father				
Siblings				

Any close relatives with: Breast Cancer: _____; Ovarian Cancer: _____ Uterine Cancer: _____
Colon Cancer: _____; Other Cancers: _____

Menstrual History

<p>If you are menopausal: Age at menopause: _____ Vaginal Bleeding since menopause (describe): _____ Hormone Replacement Therapy: ever: _____ current: _____</p>	<p>If you are still menstruating: Last menstrual period (first day): _____ Days between menstrual cycles: _____ # days bleeding per cycle: _____ Irregular or unusual vaginal bleeding: _____ Birth Control Method (if any): _____ Sterilization: yes ____ no ____</p>
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Pregnancy History

# of pregnancies	# full term births:	Vaginal Deliveries:	Cesarean Sections:	#spontaneous or therapeutic abortions:	# ectopic pregnancies:	Future pregnancy desired? Y/N
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Office use only:

VITALS: Height: _____ Weight: _____ BP: _____ P: _____

PATIENT MEDICATIONS & ALLERGIES

Patient Name: _____ Date: _____

To help us provide you with the best care while you are here at Women's Cancer Care of Seattle, please complete this form to the best of your ability. Much of the information is on the label of your prescription bottles or can be obtained from your pharmacy or doctor's office. Be sure to include all kinds of medications such as vitamins, herbal medication, supplements, and pain relievers.

My regular pharmacy: _____
City: _____ **Phone:** _____

I take no prescription, non-prescription or other medications.

	Name of Medication	Dosage	At what time(s) do you take it?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

I have no drug allergies.

Allergic to latex?	Yes	No
Tape	Yes	No
IV Contrast (X-Ray Dye)	Yes	No

	Allergy	Reaction
1		
2		
3		
4		
5		
6		

Place Label Here