[COTTAGE SURGICAL CLINICS LOGO}

GYNECOLOGIC ONCOLOGY SPECIALISTS

GYN AND BREAST SURGICAL ONCOLOGY

Anne O. Rodriguez, MD, FACS

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_

Best contact phone number(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Occupation/Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Conditions:** (Check all that apply to you, currently or in the past)

⃝ Arthritis **⃝** Cancer **⃝** Diabetes **⃝** Kidney

**⃝⁫**Sleep apnea **⃝** Mental Disorders **⃝** Skin Disorder **⃝**Stroke/TIA

⃝ Epilepsy ⃝ Rheumatic Fever ⃝High cholesterol ⃝ Thyroid

⃝High Blood Pressure/Hypertension ⃝Heart problem

**⁫** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** (Check all that apply to you)

**⃝**Appendectomy **⃝** Cardiovascular procedure **⃝**Back surgery ⃝ Hysterectomy

**⃝** Joint Replacement ⃝Gall Bladder ⃝ Hernia ⃝ Colon/Rectal surgery**⁫**

⃝ Tonsillectomy ⃝ Sinus **⃝**Carpal Tunnel

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:**  Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ latex \_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_

**Social History:** (Check all that apply to you)

Drink Alcohol: ⃝occasional ⃝often ⃝never

Cigarettes: \_\_\_\_\_past \_\_\_\_present ⃝ <1 pack/day ⃝ >1 pack/day ⃝ never

**Family History:** (Circle all that apply)

Cancer: ⃝ Mother ⃝Father ⃝Sister ⃝Brother ⃝Other relative

What type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: ⃝ Mother ⃝Father ⃝Sister ⃝ Brother ⃝Other relative

Heart Disease ⃝ Mother ⃝Father ⃝Sister ⃝Brother

Other conditions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems** – (Circle any symptoms you have had below:)

Cardiovascular: irregular heartbeat high blood pressure heart disease chest pain NONE

Respiratory: asthma bronchitis sleep apnea short of breath NONE

Allergic: hives rash vertigo cortisone use NONE

Urinary: burning urination frequent urination kidney stone blood in urine NONE

Neurologic: stroke seizures head injury aneurysm NONE

Constitutional: weight loss weight gain How many pounds?\_\_\_\_\_\_\_\_\_\_\_

Endocrine: thyroid problems diabetes hair loss NONE

Psychiatric: depression bipolar anxiety other NONE

Intestinal: heartburn/GERD/ulcer nausea/vomiting blood in stools diverticulitis NONE

Musculoskeletal: arthritis muscle weakness back pain joint pain NONE

Hematologic: easy bruising blood clots anemia fever/chills NONE