Gyn Oncology New Patient Questionnaire

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Name:__________________________

Primary Care Doctor____________________________

Referring Doctor: ____________________________

Preferred Pharmacy:_____________________________

OB/GYN History

Age of first period: ____________

Age of last period: _____________

Date of last menstrual period: ___________

Are your periods REGULAR/IRREGULAR (Circle one)

Number of pregnancies: ________

Number of live birth: ___________

Number of vaginal deliveries_____ Number of C-sections____ Number of miscarriages/abortions____

Have you ever used:

1. Oral contraceptive pills YES/NO If YES, Duration______________

2. Hormone replacement therapy YES/NO If YES, Duration______________

Medications

Name	Dose