:
Patient Name:

Gynecologic Oncology of Indiana
David H. Moore, MD

Please list any medications taken regularly (or bring a separate list to your appointment):

List any allergies or sensitivities:

List all operations you have had (operation, date, complications if any):

Health History (please check appropriate answer)

Do you have or have you ever had:	**Yes**	**No**
Problem(s) with your heart	___	___
Pneumonia, asthma or other lung problems	___	___
High blood pressure	___	___
Diabetes	___	___
Anemia	___	___
Bleeding problems	___	___
Blood transfusions	___	___
Embolism or blood clots	___	___
Jaundice or hepatitis	___	___
Seizures, convulsions, blackouts	___	___
Migraine or severe headaches	___	___
Mental illnesses	___	___
Loose or false teeth, caps, dentures	___	___
Problems with anesthesia	___	___
Do you use alcohol?	___	___
Amount: ___ drinks per day		
Do you smoke?	___	___
Amount: ___ packs per day		
Have you had a problem with drug use?	___	___
Have you ever taken hormones (excluding hormones taken for birth control)?	___	___

Family History

Has anyone in your family had:	**Yes**	**No**
Breast cancer	___	___
Ovarian cancer	___	___
Colon cancer	___	___
Other type of cancer	___	___
High blood pressure	___	___

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Heart disease	____	____
Diabetes	____	____
Stroke	____	____

Factors that may affect learning:

Who is to be taught: ☐ patient ☐ other; if other, relationship to patient ______________________________

Able to read: ☐ yes ☐ no ☐ with difficulty Comments ____

Potential barrier to learning:
☐ none ☐ blind ☐ poor vision ☐ deaf ☐ decreased hearing ☐ unable to talk ☐ memory loss ☐ learning disability ☐ inability to understand ☐ language, if other than English ____

Learns best by: ☐ reading ☐ verbal instruction ☐ practicing ☐ talking ☐ watching ☐ other __________________________

Are there any cultural or religious beliefs that need to be considered in the care?
☐ yes ☐ no If yes, explain _______________

Staff review : date/initials ______________ date/initials ______________
date/initials ______________ date/initials ______________
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Please list the names of all physicians involved in your medical care who should receive reports from my office:

I certify that the information on this questionnaire is correct to the best of my knowledge:

____ ____________________
Signed Date

Thank you very much for your time in accurately completing this questionnaire. This information is very important to me in your present and future medical care. If you do not understand a question, please make a note or leave the answer blank and we can discuss it during your office visit.

David H. Moore, MD