What isyour understanding of why you are here?

____

____

Allergies:

you know of anything you are allergic to or gives you a rash?

If so, please list:

Drug/Food	Reaction

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:

Gynecologic History:

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 typ	Age of first Diagnosis	Did you receive

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:____________
PhonenenePY 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:___________