TEXAS ONCOLOGY
Gynecologic Oncology

MRN: _____

Gynecological Patient History Questionnaire

Today's Date: _____ Patient Name: _____ Date of Birth: _____
Last First Middle or Maiden

FOR WOMEN ONLY:

Age of last period (menopause): _____
Age of first menses: _____
Date of last PAP smear: _____

Have you ever had an abnormal PAP smear? ☐ Yes ☐ No
If yes, list date & treatments: _____

Number of pregnancies: _____
Number of live births: _____

Do you or have you taken hormones, estrogen therapy or birth control pills? ☐ Yes ☐ No
If yes, what type and how long did you use them?

Name:	Length of Time:
_____	_____
_____	_____
_____	_____

Breast History:

Date of last mammogram: _____
Do you know how to perform breast self-exam? ☐ Yes ☐ No
How often do you perform breast self-exam?
☐ Monthly ☐ Every few months ☐ Few times a year ☐ Other: _____

Clinical Note Space

Please return completed form to the appropriate physician's office.