Women's Care
OF WISCONSIN, S.C.

Gynecology / Oncology New Patient Questionnaire for Dr. Vijaya Galic

Please complete this form to the best of your ability and bring it to your initial consultation.

Patient name: _____ Date of birth: _____/_____/_____

Reason for visit: _____

CURRENT MEDICAL PROBLEMS

Please list any problems for which you are currently being treated, the year diagnosed, and any significant interventions such as medications, surgeries, ER visits or hospitalizations.

Problem	Year	Intervention

Date of last mammogram: _____/_____/_____ Normal / Abnormal

Findings / Intervention: _____

Date of last colonoscopy: _____/_____/_____ Normal / Abnormal

Findings / Intervention: _____

PAST MEDICAL HISTORY

Please list significant previously treated medical problems that have resolved.

Problem	Year	Intervention

Number of pregnancies: _____ Number of deliveries: _____

Last period: _____/_____/_____ Year of menopause: _____/_____/_____

Irregular bleeding? Yes / No Heavy bleeding? Yes / No

Hormone use: _____

Date of last Pap: _____/_____/_____ HPV: + / - HPV vaccine: Yes / No

Abnormal Pap: Yes / No Treatment: _____

SURGICAL HISTORY

Please list all surgeries or major procedures you have had.

Problem	Year	Intervention

Do you accept blood products? Yes / No

If “no”, please list any acceptable components: _____

ALLERGIES / MEDICATION INTOLERANCE / ANESTHESIA REACTIONS

Please list all allergies, medication intolerances, or anesthesia reactions you have had.

Medication	Reaction

MEDICATION LIST

Please list all medications that you are taking, including how often. This includes any non-prescription medications, supplements, and herbals.

Medication	Dose/Freq	Reason

Please indicate if you have any of these symptoms currently or within the past 2 months. Please include explanations as needed.

Symptoms	Now	Prev	Symptoms	Now	Prev
Fever / chills			Nausea		
Fatigue			Vomiting		
Weight up or down?			Diarrhea		
Sweats			Constipation		
Chest pain			Bowel change		
Shortness of breath			Feeling full early		
Swelling			New heartburn		
Palpitations			Bloating		
Dizziness / fainting			Blood in stool		
Cough			Decreased appetite		
Trouble breathing			Abdominal pain		
Numbness / tingling			Mouth sores		
Weakness / paralysis			Fecal incontinence		
Visual change			Burning urination		
Headache			Blood in urine		
Easy bruising			Urinary incontinence		
Bleeding gums / nose			Urgency / frequency		
Pelvic pain			Breast complaint		
Pelvic pressure			Bone pain		
Irregular menses			Muscle pain		
Vaginal bleeding			Anxiety		
Vaginal discharge			Depression		
Vulva itching / bump			Insomnia		
Rashes			Sexual concerns		
Moles			Hot flashes		
Other:					

FAMILY CANCER HISTORY

Please complete the following cancer specific family history. In the first column, please specify the relative and specify if mother or father's side (use "M" for maternal or "P" for paternal). Use the blank areas to provide additional details if needed. An example is provided.

Relative	Breast	Ovarian	Uterine	Colon	Prostate	Melanoma	Blood Clot	Comments
Ex: Mom (M)	*60*							*chemotherapy*
	↑ **In the above columns, please specify the age of diagnosis** ↑							

To help us develop a treatment plan tailored to your unique circumstances, please answer the following questions as completely as possible.

With whom do you live? _____

What are your typical daily activities/work duties? _____

Who is available to help you during treatment? _____

Do you have advanced directives, a living will, or POLST form? Yes / No

If not, would you like assistance with completing one? Yes / No

Do you have a medical power of attorney? Yes / No

Do you have any religious/spiritual concerns that you would like to share with us to be considered as part of your treatment? Yes / No
If "yes", please list: _____

Do you presently smoke or use any nicotine containing products including e cigarettes? Yes / No

If "yes", please list the kind, the quantity, and frequency: _____

In the past, have you smoked or used any nicotine products? Yes / No

If “yes”, how much and for how long? _____

Are you interested in quitting? Yes / No

Do you consume alcohol? Yes / No

If “yes”, how many drinks per week and what type? _____

Do you utilize marijuana? Yes / No

If “yes”, in what form? _____

Have you previously or currently used any other substances recreationally? Yes / No

If “yes”, please describe: _____

Thank you for taking the time to fill out this information prior to your appointment. If you have any questions or concerns, please give us a call at 920.729.7105.

Reviewed by: _____ Date: _____/_____/_____