



GERALD A. FEUER, MD

Welcome to Atlanta Gynecologic Oncology. It is our privilege to participate in caring for your health. We strive to provide outstanding medical expertise, state of the art treatment, and compassionate care.

We believe in a team approach to health care in which the doctor and the clinical and administrative staff partner with you, the patient, to best meet your needs.

At your first visit, you'll meet Dr. Feuer and his team. A nurse will review your entire medical history and the details of your current problem. Dr. Feuer will perform a complete physical exam, including pelvic exam. He'll then explain the recommendations for treatment and answer any questions you may have about your medical problem or diagnosis. Sometimes, we'll order additional testing, like CT scans or ultrasounds, to gather more information. When surgery is the best treatment, our team will begin the scheduling process which includes a return visit for in-depth teaching with one of our nurses so you'll know what to expect.

Please review the information in this packet prior to your appointment. We have included important details about our financial and privacy policies along with a detailed history form so that we can provide the best possible care for you.

Atlanta Gynecologic Oncology employs an exceptional staff of mid-level providers (nurse practitioner and physician assistant), nurses, medical assistants and a surgical assistant with more than 45 years of combined experience in caring for gynecologic oncology patients.

We look forward to seeing you.

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# ATLANTA GYNECOLOGIC ONCOLOGY

GERALD A. FEUER, MD

THIS IS PART OF YOUR MEDICAL RECORD AND IS KEPT ABSOLUTELY CONFIDENTIAL.

COMPLETE AND ACCURATE INFORMATION ALLOWS US TO GIVE YOU THE BEST CARE POSSIBLE!

Date: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

**MAIN REASON FOR VISIT:**  pelvic mass  elevated Ca125  vaginal bleeding  abnormal Pap smear  
 fibroids  endometrial cancer  vulvar problem \_\_\_\_\_  other \_\_\_\_\_

**OBSTETRICAL HISTORY:** How many pregnancies have you had? \_\_\_\_ Vaginal deliveries \_\_\_\_ C-sections \_\_\_\_  
Tubal pregnancies \_\_\_\_ Miscarriages \_\_\_\_ Abortions \_\_\_\_ Stillbirths \_\_\_\_

**GYNECOLOGIC HISTORY:** Age at first period: \_\_\_\_\_ Date of last menstrual period: \_\_\_\_\_

If not menstruating, stopped at age: \_\_\_\_ because of  menopause  uterus removed for \_\_\_\_\_(reason)

Are your periods  regular  somewhat irregular  very irregular?

How many days between the **first day** of one period and the **first day** of your next period? \_\_\_\_\_

Menstrual flow usually lasts for \_\_\_\_ days total and is  scant  moderate  heavy  excessive with clots.

Have you missed a period without being pregnant?  Yes  No

Are you currently sexually active?  Yes  No How do you prevent pregnancy?  birth control pills

condoms  IUD  tubal ligation  menopause/uterus removed  no method  other \_\_\_\_\_

Date of last Pap smear: \_\_\_\_\_ Have you ever had an abnormal Pap smear?  Yes  No Treatment: \_\_\_\_\_

**MEDICAL PROBLEMS:** Check any problem you have been diagnosed with or received treatment for:

- |                                                         |                                                       |                                                             |
|---------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Bone disease/osteoporosis    | <input type="checkbox"/> Seizures                           |
| <input type="checkbox"/> Heart attack                   | <input type="checkbox"/> Previous cancer _____ (type) | <input type="checkbox"/> Kidney failure                     |
| <input type="checkbox"/> Heart murmur                   | <input type="checkbox"/> Jaundice/cirrhosis           | <input type="checkbox"/> Kidney stone                       |
| <input type="checkbox"/> Congestive heart failure (CHF) | <input type="checkbox"/> Gallstones                   | <input type="checkbox"/> Blood clot in leg or lung          |
| <input type="checkbox"/> Angina                         | <input type="checkbox"/> Stomach ulcer                | <input type="checkbox"/> Phlebitis                          |
| <input type="checkbox"/> High blood pressure            | <input type="checkbox"/> Hernia                       | <input type="checkbox"/> Bleeding disorder (von Willebrand) |
| <input type="checkbox"/> Atrial fibrillation            | <input type="checkbox"/> Irritable bowel syndrome     | <input type="checkbox"/> Varicose veins                     |
| <input type="checkbox"/> Mitral valve prolapse          | <input type="checkbox"/> Colitis _____                | <input type="checkbox"/> Glaucoma                           |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Chronic diarrhea             | <input type="checkbox"/> Skin disease _____                 |
| <input type="checkbox"/> Allergies/hayfever             | <input type="checkbox"/> Hemorrhoids                  | <input type="checkbox"/> Depression                         |
| <input type="checkbox"/> Bronchitis                     | <input type="checkbox"/> Arthritis                    | <input type="checkbox"/> Anxiety                            |
| <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Fibromyalgia                 | <input type="checkbox"/> Bipolar                            |
| <input type="checkbox"/> COPD                           | <input type="checkbox"/> Sjogren's syndrome           | <input type="checkbox"/> Schizophrenia                      |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Back/neck/spine problems     | <input type="checkbox"/> Dementia/Alzheimer's               |
| <input type="checkbox"/> Thyroid                        | <input type="checkbox"/> Migraines _____ (how often?) | <input type="checkbox"/> Other _____                        |

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Usual Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**MEDICATIONS AND SUPPLEMENTS:** Please list all medications, supplements, and herbs.

	Name of medication	Dosage	When do you take it?	Who prescribed it?
Diabetes				
Heart/Blood Pressure				
Anxiety/ Depression				
Other				
Over the Counter				
Herbs/Vitamins/ Supplements				

**Preferred Pharmacy:**  CVS  Rite Aid  Walmart  Kroger  Publix  Walgreens  Other \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**ALLERGIES:** Please list all allergies to **medications, foods and materials** (i.e., latex, adhesive, etc.) and the type of reaction (for example, hives, rash, swelling of throat, vomiting, etc.).

Medication & Reaction	Medication & Reaction

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**DOCTORS:** Please list the doctors who care for you.

Specialty	Name	Phone	Send notes?*
Gyn			<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Mark yes if you would like us to send information to your other doctors after each office visit.

**INFECTIOUS DISEASE:** Check any of the following that you have had:

- Pneumonia  Rheumatic Fever  Tuberculosis  Herpes, last outbreak \_\_\_\_\_  Syphilis  Chlamydia  
 Gonorrhea  HIV  Hepatitis type \_\_\_\_  Tubal infection (PID)  Frequent bladder or kidney infections or one treated in the hospital  Abscess, describe: \_\_\_\_\_

**SCREENING AND DIAGNOSTIC TESTS:**

Date of last mammogram: \_\_\_\_\_ Date of last colonoscopy: \_\_\_\_\_

In the last year, have you had any  X-rays  CT scans  MRI scans  ultrasounds (sonograms)?

If yes, list body part imaged and the facility where performed: \_\_\_\_\_

**SURGERY:** Please list all previous surgeries.

Year	Gyn/Breast Surgery (any surgery on ovary, uterus, cervix, D&C, LEEP, C-section)	Year	Orthopedic Surgery (knee, hip replacement, back or bone surgery)
Year	Other Abdominal Surgery (colon, hernia, bowel, stomach, gallbladder)	Year	Heart Surgery (valve or bypass surgery, stents, pacemaker/defibrillator)
Year	Other Surgery (eye, lung, kidney, etc.)		

Have you ever been advised to have any surgical procedure which has not been done?  No  Yes: \_\_\_\_\_

Have you been hospitalized for any illnesses?  No  Yes, reason/year: \_\_\_\_\_

Have you ever had a blood transfusion?  No  Yes, year: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**FAMILY HISTORY:** Please list any family member diagnosed with these diseases and whether they are alive (A) or deceased (D) **from this disease.**

	<b>Close Family Members</b> (child, sibling or parent)	<b>Extended Family Members</b> (aunts, uncles, grandparents, cousins)
Ovarian Cancer		
Breast Cancer		
Endometrial Cancer		
Cervical Cancer		
Prostate Cancer		
Colon Cancer		
Other Cancer		
Diabetes		
Tuberculosis		
Stroke		
High blood pressure		
Heart attack		

**SOCIAL HISTORY:**

Do you **smoke**?  Yes  No Packs per day: \_\_\_\_\_ Number of years: \_\_\_\_\_ When did you quit? \_\_\_\_\_

Do you use any other form of tobacco?  Yes  No If yes, type: \_\_\_\_\_

Do you use **alcohol**?  Yes  No Amount per week? \_\_\_\_\_ Type: \_\_\_\_\_

Have you ever used **drugs**?  Yes  No  Past  Present What type? \_\_\_\_\_

Do you **exercise** routinely?  Yes  No How often per week? \_\_\_\_\_ What type? \_\_\_\_\_

Do you have concerns about your **personal safety**, the personal safety of anyone in your home, or the security of your property?  Yes  No

**Marital Status:**  Single  Married  Divorced  Widowed  Domestic partner

**Ages of children:** \_\_\_\_\_

**Education:**  High school  College  Graduate School

**Occupation:** \_\_\_\_\_  Retired  Disabled due to \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**SYSTEM REVIEW:** Check any of the following symptoms that you have now or have had in the past six months.

<b>General</b>	<input type="checkbox"/> fevers <input type="checkbox"/> weakness/excessive fatigue	<input type="checkbox"/> weight loss ____lbs	<input type="checkbox"/> weight gain ____lbs
<b>Skin</b>	<input type="checkbox"/> sores <input type="checkbox"/> new moles or freckles	<input type="checkbox"/> rashes <input type="checkbox"/> loss of skin pigment	<input type="checkbox"/> itching
<b>Neurologic</b>	<input type="checkbox"/> seizures/convulsions <input type="checkbox"/> numbness/tingling	<input type="checkbox"/> tremor <input type="checkbox"/> loss of consciousness/fainting	<input type="checkbox"/> severe headaches
<b>Eyes, Ears, Nose, Throat</b>	<input type="checkbox"/> ringing in the ears <input type="checkbox"/> chronic sinus infections <input type="checkbox"/> frequent throat infections	<input type="checkbox"/> any eye disease or injury _____ <input type="checkbox"/> any ear disease or injury _____ Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No	contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Breasts</b>	<input type="checkbox"/> nipple discharge	<input type="checkbox"/> change in breast size	<input type="checkbox"/> new or changing lumps
<b>Respiratory</b>	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> chronic or frequent cough	<input type="checkbox"/> bloody sputum
<b>Cardiovascular</b>	<input type="checkbox"/> chest pain	<input type="checkbox"/> rapid/irregular heartbeat	<input type="checkbox"/> swelling of feet or ankles
<b>Gastrointestinal</b>	<input type="checkbox"/> diarrhea <input type="checkbox"/> vomiting <input type="checkbox"/> blood in stool <input type="checkbox"/> unable to control bowels	<input type="checkbox"/> constipation <input type="checkbox"/> heartburn or indigestion <input type="checkbox"/> black or tarry stool <input type="checkbox"/> urgency of bowel movements	<input type="checkbox"/> nausea <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> abdominal cramps or pain
<b>Gynecologic</b>	<input type="checkbox"/> pelvic pain <input type="checkbox"/> painful sex <input type="checkbox"/> vaginal irritation/itching <input type="checkbox"/> vulvar irritation/itching <input type="checkbox"/> sores or lumps around the vulva or vagina	<input type="checkbox"/> bleeding/spotting between periods <input type="checkbox"/> bleeding/spotting after sex <input type="checkbox"/> vaginal discharge <input type="checkbox"/> bulging sensation in the vagina	<input type="checkbox"/> painful periods <input type="checkbox"/> vaginal dryness <input type="checkbox"/> lumps in the groin
<b>Urinary</b>	<input type="checkbox"/> frequent urination <input type="checkbox"/> dribbling of urine <input type="checkbox"/> bedwetting	<input type="checkbox"/> painful urination <input type="checkbox"/> sudden urgent need to urinate <input type="checkbox"/> loss of urine with sneezing or coughing	<input type="checkbox"/> night urination
<b>Musculoskeletal</b>	<input type="checkbox"/> back pain <input type="checkbox"/> muscle weakness	<input type="checkbox"/> joint pain/stiffness	<input type="checkbox"/> leg cramps or limp
<b>Endocrine</b>	<input type="checkbox"/> unusual hair growth <input type="checkbox"/> salt cravings	<input type="checkbox"/> hair loss <input type="checkbox"/> hot flashes	<input type="checkbox"/> abnormal thirst
<b>Psychiatric</b>	<input type="checkbox"/> nightmares <input type="checkbox"/> excessive worry/stress/tension	<input type="checkbox"/> insomnia	<input type="checkbox"/> depression

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_