**PROFESSOR**
**Yusuf Yıldırım, MD**
**SURGICAL & GYNECOLOGIC ONCOLOGY**



## HEALTH INFORMATION FORM

First name: _____ Last name: _____ Today's date: _____

Date of birth: _____ Height: _____ Weight: _____

Sex: ☐ Female ☐ Male Preffered language: _____

Address: _____

_____

City: _____ Country: _____ Zip: _____

Home or work phone: (_____)_____ Cell phone: (_____)_____

Email address: _____ May we send information here? ☐ Yes ☐ No

In case of emergency; Contact _____ Relation _____ Phone (_____)_____

Primary health insurance: _____ Secondary health insurance: _____

Do you have pacemaker or metal implants in your body? ☐ No ☐ Yes : _____

Do you have any objections to a blood transfusion? ☐ No ☐ Yes : _____

How is your general health? ☐ Good ☐ Fair ☐ Poor

Have you had any falls in past 6 months -or- do you think you are at risk of falling? ☐ No ☐ Yes

How is your self care? Please check if you need help with any of these activities:

☐ Dressing ☐ Walking ☐ Cooking meals ☐ Bathing ☐ Transportation ☐ Other: _____

Do you have pain? ☐ No ☐ Yes If yes; 1-Starting date _____

2-What would you give out of 10 for its intensity? _____

Reason for visit: _____

_____

Have you been hospitalized for the present condition ☐ No ☐ Yes (date: _____ )

Have you had surgery for the present condition? ☐ No ☐ Yes (date: _____ )

_____

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**First name: _____ Last name: _____ Today's date: _____**

| **Social/Personal History** | |
|---|---|
| Your highest level of education completed | ☐ Elementary school ☐ Secondary school<br>☐ High school ☐ University ☐ Post-graduate degree |
| What is your profession/occupation? | |
| Are you employed? | ☐ No ☐ Retired ☐ Yes |
| Marital status | ☐ Married ☐ Divorced ☐ Separated<br>☐ Single ☐ Widow/er ☐ Other |
| Are you sexually active? | ☐ No ☐ Yes<br>If yes,<br>Contraception: ☐ No ☐ Yes (method: _____) |
| Do you have chidren? | ☐ No ☐ Yes<br>If yes, number of children: _____ |
| Do you want to have children in the future? | ☐ No ☐ Yes |
| Dou you exercise? | ☐ No ☐ Yes<br>If yes,<br>Type of exercise: _____<br>How much per week: _____ hours |
| Do you smoke cigarettes? | ☐ Never ☐ Quit (Date quit: _____, No of years smoked___)<br>☐ Yes (___ packs per day, No of years:_____) |
| Do you drink alcohol? | ☐ No ☐ Yes<br>If yes,<br>Drinks per week: _____<br>Alcohol problem: ☐ No ☐ Yes |
| Do you use recreational drugs? | ☐ No ☐ Yes<br>If yes,<br>Type of drugs: _____ |

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**First name: _____ Last name: _____ Today's date: _____**

| **Family History** | |
|---|---|
| FATHER | ☐Diabetes ☐Hypertension ☐Heart Disease ☐Lung Disease ☐Liver Disease ☐Kidney Disease ☐Thyroid Disease ☐Obesity ☐Depression ☐Osteoporosis ☐Thromboembolism (Blood clots) ☐Neurological Disorders ☐Rheumatic Diseases or Vasculitis ☐Cancer; type:_____ age at diagnosis:____ |
| MOTHER | ☐Diabetes ☐Hypertension ☐Heart Disease ☐Lung Disease ☐Liver Disease ☐Kidney Disease ☐Thyroid Disease ☐Obesity ☐Depression ☐Osteoporosis ☐Thromboembolism (Blood clots) ☐Neurological Disorders ☐Rheumatic Diseases or Vasculitis ☐Cancer; type:_____ age at diagnosis:____ |
| BROTHER(S)/SISTER(S) | ☐Diabetes ☐Hypertension ☐Heart Disease ☐Lung Disease ☐Liver Disease ☐Kidney Disease ☐Thyroid Disease ☐Obesity ☐Depression ☐Osteoporosis ☐Thromboembolism (Blood clots) ☐Neurological Disorders ☐Rheumatic Diseases or Vasculitis ☐Cancer; type:_____ age at diagnosis:____ |
| CHILDREN | ☐Diabetes ☐Hypertension ☐Heart Disease ☐Lung Disease ☐Liver Disease ☐Kidney Disease ☐Thyroid Disease ☐Obesity ☐Depression ☐Osteoporosis ☐Thromboembolism (Blood clots) ☐Neurological Disorders ☐Rheumatic Diseases or Vasculitis ☐Cancer; type:_____ age at diagnosis:____ |
| SECOND-DEGREE RELATIVES (uncles, aunts, nephews, nieces, grandparents, grandchildren) | ☐Diabetes ☐Hypertension ☐Heart Disease ☐Lung Disease ☐Liver Disease ☐Kidney Disease ☐Thyroid Disease ☐Obesity ☐Depression ☐Osteoporosis ☐Thromboembolism (Blood clots) ☐Neurological Disorders ☐Rheumatic Diseases or Vasculitis ☐Cancer; type:_____ age at diagnosis:____ |

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**First name: _____ Last name: _____ Today's date: _____**

| **Preventive Care** | (Please skip the dates you cannot remember) | |
|---|---|---|
| Recent Immunization Shots | ☐ Flu | Date: |
| | ☐ Tetanus | Date: |
| | ☐ Pneumonia | Date: |
| | ☐ Hep B (Hepatitis B) | Date: |
| | ☐ HPV (Human Papilloma Virus) | Date: |
| | ☐ Covid 19 | Date: |
| Recent Screening Tests | ☐ Chest X-ray | Date: |
| | ☐ Gastroscopy | Date: |
| | ☐ Colonoscopy or CT colonography (CTC) | Date: |
| | ☐ Stool test | Date: |
| | ☐ Mammogram (women only) | Date: |
| | ☐ Pap-test and/or HPV test (women only) | Date: |
| | ☐ Blood tumor marker tests | Date: |

| **Allergies & Drug Reactions** | |
|---|---|
| Antibiotic allergy | ☐ Unknown ☐ No ☐ Yes If yes, name of antibiotic(s) _____ |
| Food allergy | ☐ Unknown ☐ No ☐ Yes If yes, name of food _____ |
| Latex allergy | ☐ Unknown ☐ No ☐ Yes |
| Pollen allergy | ☐ Unknown ☐ No ☐ Yes |
| Bee siting allergy | ☐ Unknown ☐ No ☐ Yes |
| Local anesthetics | ☐ Unknown ☐ No ☐ Yes If yes, name of local anesthetic(s)_____ |
| Aspirin | ☐ Unknown ☐ No ☐ Yes If yes, type of reaction _____ |
| Sulfa drugs | ☐ Unknown ☐ No ☐ Yes If yes, type of reaction _____ |
| Cortisone | ☐ Unknown ☐ No ☐ Yes If yes, type of reaction _____ |
| Codein | ☐ Unknown ☐ No ☐ Yes If yes, type of reaction _____ |
| Carboplatin | ☐ Unknown ☐ No ☐ Yes If yes, name of reaction _____ |
| Are you allergic to anything else, or have you ever experienced any reaction with any other medications? | ☐ No ☐ Yes<br>If yes, please list the things or drugs: _____<br>_____<br>_____ |

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**First name: _____ Last name: _____ Today's date: _____**

| **Medical History** (Do you have or have you ever had any of following conditions?) | |
|---|---|
| Anemia | □ No □ Yes |
| Diabetes | □ No □ Yes |
| High blood pressure | □ No □ Yes |
| Heart attack (infarction) | □ No □ Yes |
| Arrhythmia | □ No □ Yes |
| Heart murmur | □ No □ Yes |
| Heart valve diseases | □ No □ Yes |
| Congestive heart failure | □ No □ Yes |
| Chest pain | □ No □ Yes |
| Coronary artery disease | □ No □ Yes |
| Chronic bronchitis /COPD | □ No □ Yes |
| Asthma | □ No □ Yes |
| Tuberculosis | □ No □ Yes |
| HIV/AIDS | □ No □ Yes |
| Thrombosis or phlebitis | □ No □ Yes |
| Bleed or bruise easily | □ No □ Yes |
| Hepatitis B or C | □ No □ Yes |
| Cirrhosis | □ No □ Yes |
| Renal failure | □ No □ Yes |
| Glaucoma | □ No □ Yes |
| Dryness of eyes | □ No □ Yes |
| Vision impairment/loss | □ No □ Yes |
| Cancer | □ No □ Yes |
| Radiation therapy | □ No □ Yes |
| Chemotherapy | □ No □ Yes |
| Smart drugs/Immunotherap. | □ No □ Yes |
| Gout | □ No □ Yes |
| Rheumatic fever | □ No □ Yes |
| Romatoid arthritis | □ No □ Yes |
| Lupus (SLE) | □ No □ Yes |
| Gastritis or peptic ulcer | □ No □ Yes |
| Gastroesophageal reflux | □ No □ Yes |
| Hashimato's disease | □ No □ Yes |

| | |
|---|---|
| Hypothyroidism | □ No □ Yes |
| Hyperthyroidism | □ No □ Yes |
| Depression | □ No □ Yes |
| Bipolar disease | □ No □ Yes |
| Anxiety or panic disorders | □ No □ Yes |
| Mental problems | □ No □ Yes |
| Cerebrovasculary disease | □ No □ Yes |
| Varicose veins | □ No □ Yes |
| Chronic venouse stasis | □ No □ Yes |
| Epilepsy (Seizures) | □ No □ Yes |
| Difficulty in wound healing | □ No □ Yes |
| Problems with scarring | □ No □ Yes |
| High cholesterol | □ No □ Yes |
| Hearing impairment/loss | □ No □ Yes |
| Multiple sclerosis | □ No □ Yes |
| Parkinson's disease | □ No □ Yes |
| Demantia | □ No □ Yes |
| Migraine | □ No □ Yes |
| Vertigo | □ No □ Yes |
| Osteoporosis | □ No □ Yes |
| Electrolyte imbalance | □ No □ Yes |
| Gallstones or cholecystitis | □ No □ Yes |
| Pancreatitis | □ No □ Yes |
| Ulcerative colitis | □ No □ Yes |
| Crohn's disease | □ No □ Yes |
| Irritable bowel syndrome | □ No □ Yes |
| Stoma | □ No □ Yes |
| Urinary incontinence | □ No □ Yes |
| Hypoglicemia | □ No □ Yes |
| Sexually transmitted disease | □ No □ Yes |
| Skin abnormalities | □ No □ Yes |
| Sleep problems | □ No □ Yes |
| Lymphedema | □ No □ Yes |
| Gluten intolerance | □ No □ Yes |
| Genetic mutation(s) | □ No □ Yes |
| Other significant illess(es) | □ No □ Yes |

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## Current Medications

(Please list any medications you are taking, including non-prescription drugs, vitamins and herbals)

| | Name of medication | Dose | Times per day | Starting date |
|---|---|---|---|---|
| 1 | | | | ___/___/_____ |
| 2 | | | | ___/___/_____ |
| 3 | | | | ___/___/_____ |
| 4 | | | | ___/___/_____ |
| 5 | | | | ___/___/_____ |
| 6 | | | | ___/___/_____ |
| 7 | | | | ___/___/_____ |

## Surgical History

(Please list previous surgeries including biopcy procedures)

| | Name of surgery | Date | Anesthesia Type | Excessive bleeding | Blood Trans-fusion | ICU admis-sion | Other peri-operative problems |
|---|---|---|---|---|---|---|---|
| 1 | | ___/___/_____ | ☐ General<br>☐ Epidural<br>☐ Local | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | |
| 2 | | ___/___/_____ | ☐ General<br>☐ Epidural<br>☐ Local | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | |
| 3 | | ___/___/_____ | ☐ General<br>☐ Epidural<br>☐ Local | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | |
| 4 | | ___/___/_____ | ☐ General<br>☐ Epidural<br>☐ Local | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | ☐ No<br>☐ Yes | |

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**First name: _____ Last name: _____ Today's date: _____**

| **Symptoms**<br>(Please tick any symptoms you have) | | |
|---|---|---|
| 1 | General & Cardiopulmonary | ☐Fever ☐Fatigue ☐Weakness ☐Unwanted weight loss ☐Weight gain ☐Cough ☐Wheezing ☐Shortness of breath ☐Chest pain ☐Irregular heart beat ☐Swelling of the legs ☐Bone pain ☐Eyesight problem ☐Hearing problem ☐Swollen lymph nodes ☐Excessive sweating ☐Heat intolerance ☐Cold intolerance ☐Paleness or anemia ☐Fainting ☐Headache ☐Depression ☐Sleep problems ☐Difficulty or painful urination ☐Urinary incontinence ☐Excessive urination ☐Blood in urine ☐Skin problems ☐Itching ☐Jaundice |
| 2 | Gastrointestinal & Abdominal | ☐Loss of appetite ☐Nausea or vomiting ☐Indigestion ☐Heartburn (reflux) ☐Swallowing trouble ☐Feeling full quickly ☐Bloating in the belly or gas ☐Abdominal pain, cramps or discomfort ☐Change in bowel habits ☐Diarrhea ☐Constipation ☐Abdominal swelling ☐Blood on or in the stool ☐Constantly feeling of rectal fullness or pressure ☐Narrow stool ☐Pain when defecating ☐Anal pruritis (itching) ☐Anal mass, lump or ulcer ☐Leaking stool ☐Swelling or lump in the groin area |
| 3 | Gynecologic & Breast (women only) | ☐Excessive/irregular bleeding ☐Vaginal bleeding after menopause ☐Hot flashes ☐An unusual discharge ☐Pain during sex ☐Pelvic pain or pressure ☐Vulvar lump, swelling or ulcer ☐Vulvar itching or burning ☐Swelling or lump in the groin area ☐Infertility ☐Dysmenorrhea (painful periods) ☐Genital wart(s) ☐Breast lump or mass ☐Breast skin dimpling or orange peel appearance ☐Pain in the breast ☐Nipple discharge ☐Nipple retraction ☐Swollen lymph nodes in underarm |

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**First name: _____ Last name: _____ Today's date: _____**

## Diagnostic Tests

(Please tick the diagnostic test or tests applied to you for your current condition)

| | | |
|---|---|---|
| 1 | Imaging Tests | ☐Ultrasound ☐X-Ray ☐Computed Tomography (CT) ☐PET/CT scan ☐Magnetic Resonance Imaging (MRI) ☐Mammography ☐Angiography ☐Bone scan ☐Bone density ☐Thyroid scan ☐Fluoroscopy ☐Intravenous Pyelography (IVP) ☐Radionuclide scan ☐ERCP ☐Other: _____ |
| 2 | Blood Tests (Tumor Marker) | ☐CEA ☐Ca125 ☐Ca19.9 ☐Ca15.3 ☐HE4 ☐Inhibin ☐OVA1 panel ☐Human chorionic gonadotropin (hCG) ☐Estradiol (E2) ☐Alpha-fetoprotein (AFP) ☐5-HIAA ☐Somatostatin receptor ☐Neuron-specific enolase (NSE) ☐PSA ☐Lactate dehydrogenase (LDH) ☐Other: _____ |
| 3 | Biopsy | from tumor in: ☐Colon or rectum ☐Anus ☐Stomach ☐Liver ☐Bone ☐Uterine cervix ☐Endometrium ☐Soft tissue ☐Vulva ☐Skin ☐Breast ☐Lymph node(s) ☐Peritoneum or omentum ☐Other: _____ |
| 4 | Diagnostic/Staging Laparoscopy | for: ☐Ovarian cancer ☐Colorectal cancer ☐Appendix cancer ☐Stomach cancer ☐Gastrointestinal stromal tumor (GIST) ☐Sarcoma ☐Neuroendocrine tumor ☐Primary peritoneal cancer ☐Cancer of unknown primary (CUP) ☐Other: _____ |
| 5 | Endoscopy | ☐Colonoscopy or Sigmoidoscopy ☐Gastroduodenoscopy ☐Cystoscopy ☐Hysteroscopy ☐Colposcopy ☐Bronchoscopy ☐Other: _____ |
| 6 | Other | _____ |

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**First name: _____ Last name: _____ Today's date: _____**

| Is there any other information regarding your status that we should know about? |
|---|
| ☐ No<br>☐ Yes<br>If yes, please indicate below: |

I confirm to the best of my knowledge that THE ABOVE INFORMATION IS TRUE AND ACCURATE

**Signature of Patient**: _____

**Date**: _____