

PROFESSOR
Yusuf Yıldırım, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 1 of 9

HEALTH INFORMATION FORM

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

Date of birth: _____ Height: _____ Weight: _____

Sex: Female Male Preferred 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: _____)

PROFESSOR
Yusuf Yildirim, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 2 of 9

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

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

PROFESSOR
Yusuf Yildirim, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 3 of 9

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

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

PROFESSOR
Yusuf Yıldırım, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 4 of 9

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

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

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

PROFESSOR
Yusuf Yıldırım, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 5 of 9

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

Medical History (Do you have or have you ever had any of following conditions?)	
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes
High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart attack (infarction)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Arrhythmia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Heart valve diseases	<input type="checkbox"/> No <input type="checkbox"/> Yes
Congestive heart failure	<input type="checkbox"/> No <input type="checkbox"/> Yes
Coronary artery disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pulmonary (lung) disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Tuberculosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
HIV/AIDS	<input type="checkbox"/> No <input type="checkbox"/> Yes
Thrombosis or phlebitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Bleed or bruise easily	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hepatitis B or C	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cirrhosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Renal failure	<input type="checkbox"/> No <input type="checkbox"/> Yes
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Chemotherapy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Radiation therapy	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gout	<input type="checkbox"/> No <input type="checkbox"/> Yes
Rheumatic fever	<input type="checkbox"/> No <input type="checkbox"/> Yes
Romatoid arthritis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Lupus (SLE)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gastritis or peptic ulcer	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gastroesophageal reflux	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hashimoto's disease	<input type="checkbox"/> No <input type="checkbox"/> Yes

Hyperthyroidism	<input type="checkbox"/> No <input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No <input type="checkbox"/> Yes
Anxiety or panic disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
Cerebrovascular disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Varicose veins	<input type="checkbox"/> No <input type="checkbox"/> Yes
Epilepsy (Seizures)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Difficulty in wound healing	<input type="checkbox"/> No <input type="checkbox"/> Yes
High cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing impairment/loss	<input type="checkbox"/> No <input type="checkbox"/> Yes
Multiple sclerosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Parkinson's disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Demantia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Migraine	<input type="checkbox"/> No <input type="checkbox"/> Yes
Osteoporosis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Electrolyte imbalance	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gallstones or cholecystitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Pancreatitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Ulcerative colitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Crohn's disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Irritable bowel syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes
Urinary incontinence	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hypoglicemia	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sexually transmitted disease	<input type="checkbox"/> No <input type="checkbox"/> Yes
Skin abnormalities	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sleep problems	<input type="checkbox"/> No <input type="checkbox"/> Yes
Lymphedema	<input type="checkbox"/> No <input type="checkbox"/> Yes
Gluten intolerance	<input type="checkbox"/> No <input type="checkbox"/> Yes
Genetic mutation(s)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other significant illness(es)	<input type="checkbox"/> No <input type="checkbox"/> Yes

PROFESSOR
Yusuf Yıldırım, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 6 of 9

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

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 biopsy procedures)

	Name of surgery	Date	Anesthesia Type	Excessive bleeding	Blood Transfusion	ICU admission	Other peri-operative problems
1		___/___/_____	<input type="checkbox"/> General <input type="checkbox"/> Epidural <input type="checkbox"/> Local	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
2		___/___/_____	<input type="checkbox"/> General <input type="checkbox"/> Epidural <input type="checkbox"/> Local	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3		___/___/_____	<input type="checkbox"/> General <input type="checkbox"/> Epidural <input type="checkbox"/> Local	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4		___/___/_____	<input type="checkbox"/> General <input type="checkbox"/> Epidural <input type="checkbox"/> Local	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	

PROFESSOR
Yusuf Yildirim, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 7 of 9

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

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

PROFESSOR
Yusuf Yildirim, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 8 of 9

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

PROFESSOR
Yusuf Yıldırım, MD
SURGICAL & GYNECOLOGIC ONCOLOGY

Page 9 of 9

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

Is there any other information regarding your status that we should know about?

No

Yes

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: _____