Prof.
Yusuf Yıldırım, MD
Surgical Oncology & 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; Starting date _____

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

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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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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 If yes, please list the things or drugs: _____ _____ _____

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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/apnea	□ 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 ☐ Epidural ☐ Local	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	
2		___/___/_____	☐ General ☐ Epidural ☐ Local	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	
3		___/___/_____	☐ General ☐ Epidural ☐ Local	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	
4		___/___/_____	☐ General ☐ Epidural ☐ Local	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	

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Symptoms (Please tick any symptoms you have)	
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
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
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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Diagnostic Tests (Please tick the diagnostic test or tests applied to you for your current condition)	
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: _____
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: _____
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: _____
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: _____
Endoscopy	☐Colonoscopy or Sigmoidoscopy ☐Gastroduodenoscopy ☐Cystoscopy ☐Hysteroscopy ☐Bronchoscopy ☐Other: _____
Other	

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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: _____