

FEMALE PATIENT FORM

Emerald Coast Cancer Center

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*Please fill out the following form in order to assist us with the move to our new medical records system.
Thank You.*

Patient Name: _____ **Date Of Birth:** _____

Tobacco Use and Cessasion Counseling

Tobacco Use

_____ Non Smoker _____ Current Every Day Smoker _____ Current Some Day Smoker _____ Heavy Tobacco Smoker
_____ Light Tobacco Smoker _____ Former Smoker _____ Pipe Smoker _____ Chews Tobacco _____ Snuff User
_____ User of Moist Powdered Tobacco _____ Never Smoker _____ Years Discontinued _____ Number of Years of Use
_____ Pack(s) Per Day _____ Pack(s) Per Year History
Type: _____ Cigarettes _____ Cigars _____ Pipe _____ Smokeless Tobacco
_____ E-Cigarettes

Smoking Cessasion Counseling

_____ N/A _____ Advised to Quit _____ Discussed Cessation Methods _____ Discussed Cessation Medications
_____ Not Discussed

Alcohol

_____ Never _____ Current _____ Social _____ Former
If Former Please Provide Date Stopped _____

_____ Drinks Per Day _____ Drinks Per Month
Type: _____ Wine _____ Beer _____ Spirits

Recreational Drug Use

_____ Yes _____ No

Marital Status

_____ Never _____ Single _____ Married _____ Partnered _____ Separated
_____ Divorced _____ Widowed

Children

_____ Yes _____ No _____ If Yes, How Many Children Do You Have? _____

Occupation/Employment

____ Full Time Employment ____ Part Time Employment ____ Retired ____ Disabled
____ Full Time Student ____ Part Time Student ____ Never Employed ____ Other or N/A

If currently employed please list current occupation:

If retired or disabled please list former occupation:

Secondary occupation (if applicable)

Occupation Exposure

____ Not Evaluated ____ No Occupational Exposure ____ Occupational Exposure
____ N/A

If so what type of occupational exposure?

Gynecological History

Menstrual History

____ Age at First Menstration ____ Age at Menopause
____ Regular Menstral Flow ____ Irregular Menstral Flow
____ Normal Flow ____ Light Flow ____ Heavy Flow
____ Date of Last Menstral Period

Maternity

____ How Many Pregnancies ____ How Many Live Births
____ Age at First Full Term Pregnancy

Breastfed- ____ Yes ____ No

Hysterectomy

____ Yes ____ No

If Yes: ____ Partial Hysterectomy ____ Complete Hysterectomy

Hormone Use

____ None ____ Birth Control ____ Number of Years Taken _____ Type

____ Continued Use ____ Year Stopped

____ Hormone Replacement Therapy ____ Number of Years Taken _____ Type

____ Continued Use ____ Year Stopped _____ Other

Health Maintenance

Colonoscopy

____ Never OR ____ Date of Last Colonoscopy

Please List the Physician That Performed Your Last Colonoscopy

Stomach Scope (EGD)

____ Never OR ____ Date of Last Stomach Scope (EGD)

Please List the Physician That Performed Your Last Stomach Scope (EGD)

Mammogram

_____ Never OR _____ Date of Last Mammogram

Please List the Physician or Facility That Performed Your Last Mammogram _____

Monthly Self Breast Exam

_____ Yes _____ No _____ Sporadic

Pap Smear

_____ Never OR _____ Date of Last Pap Smear

Please List the Physician That Performed Your Last Pap Smear _____

Bone Density

_____ Never OR _____ Date of Last Bone Density

Facility Bone Density Done At: _____

Vaccination Record

Influenza (Flu Shot) _____ Yes _____ No _____ Date of Influenza (Flu) Shot

Shingles _____ Yes _____ No _____ Date of Shingles Vaccination

Pneumovax _____ Yes _____ No _____ Date of Pneumovax

COVID-19 _____ Yes _____ No _____ Date of COVID-19 Vaccination

Other Vaccination(s) _____

Family History

Mother _____ Living _____ Deceased

If Deceased Please List Age and Cause of Death _____

Father _____ Living _____ Deceased

If Deceased Please List Age and Cause of Death _____