



Name: _____ Date of Birth: _____ Today's Date: _____

Medical History (any new from last visit):

- Asthma
- Arthritis
- Heart Murmur
- Heart Disease
- Stroke
- Epilepsy
- Migraines
- Lupus
- Emphysema
- Depression/Mental Illness
- High Blood Pressure
- HIV
- Kidney Disease
- Osteoporosis
- Cholesterol
- Thyroid Disease: **Hyperthyroid**
- Thyroid Disease: **Hypothyroid**
- Ovarian Cysts
- Diabetes: **Type 1**
- Diabetes: **Type 2**
- Polycystic Ovaries (PCOS)
- Endometriosis
- Uterine Fibroids
- Cancer (Please specify type) _____
- Other: _____

Social History: (please circle) Single Married Divorced Widowed Female Partner Male Partner

Occupation: _____ Student: Yes No

Do you use tobacco? Yes No Previously How many packs/cigarettes per day? _____

Do you use alcohol? Yes No Previously How many drinks per day/week? _____

Do you use drugs? Yes No Previously What kind? _____ How Often? _____

OB/GYN History:

First day of your last period: _____

Age of first period: _____ How Long do your periods last? _____ How many days between periods? _____

Cramping during periods? Yes No Flow: Heavy Medium Light Clots: Yes No

Are you currently sexually active?.....Yes No

Is your current sexual partner(s)?.....Male Female Both

Do you have a history of sexually transmitted diseases? Yes No Please specify type: _____

What do you currently use for contraception? _____

What have you previously used? IUD Pills Condoms Patch Nuvaring Other: _____

Date of last pap smear: _____ Normal Abnormal Date of last mammogram: _____ Normal Abnormal

Date of last colonoscopy: _____ Normal Abnormal Date of last bone density: _____ Normal Abnormal

How many times have you been pregnant? _____ Number of children? _____

Date of delivery	Weeks at delivery	C-section/ vaginal	Male/Female	Baby's birth weight	Complications
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Name: _____

Surgical History (any new from last visit)

Date	Type of surgery	Date	Type of surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medication (please include vitamins and over the counter medications):

Medication	Dosage (mg, IU)	How often do you take it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (please include medications, environmental, and food allergies):

Allergy	Reaction (hives, swelling, etc)	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History (please include relationship to you, i.e. parents, siblings, grandparents):

- | | | |
|---|--|--|
| <input type="checkbox"/> Diabetes: Type 1 _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Ovarian Cancer |
| <input type="checkbox"/> Diabetes: Type 2 _____ | <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Other Cancer (please specify) _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Lupus _____ | _____ |
| <input type="checkbox"/> Depression/Mental Illness _____ | <input type="checkbox"/> Heart Disease _____ | _____ |
| <input type="checkbox"/> Thyroid Disease: Hypothyroid _____ | <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Thyroid Disease: Hyperthyroid _____ | <input type="checkbox"/> Breast Cancer _____ | _____ |
| <input type="checkbox"/> Kidney Disease _____ | <input type="checkbox"/> Colon Cancer _____ | _____ |

Review of Symptoms (Please include any symptoms or problems you are experiencing today):

Concerns of problems you would like to discuss today: _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Tired/Fatigue | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bleeding from gums | <input type="checkbox"/> Memory/concentration difficulty | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Decreased libido (sex drive) | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Shortness of breath with exercise | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Breast lump |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Intolerance to cold | <input type="checkbox"/> Breast tenderness |
| <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Intolerance to heat | <input type="checkbox"/> Nipple discharge |
| <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Urinary urgency | <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heartburn |

Hereditary Cancer Syndrome Risk Assessment

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

This is a screening tool for the common features of Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome.

Instruction:

- Please circle **Y** for those that apply to **YOU and/or YOUR FAMILY** (on both your mothers or fathers side).
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family member should be considered:

Mother, Father, Brother, Sister, Children, Nieces/Nephews

Maternal – Grandmother, Grandfather, Aunts, Uncles, First Cousins

Paternal - Grandmother, Grandfather, Aunts, Uncles, First Cousins

Y	N	Have you ever been tested for hereditary risk of cancer (BRCA testing or Lynch Syndrome Testing)? If yes, please explain:
Y	N	Have any members of your family ever been tested for hereditary risk of cancer (BRCA testing or Lynch Syndrome Testing)? If yes, please explain:

BREAST AND OVARIAN CANCER		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Ashkenazi Jewish ancestry with breast or ovarian cancer diagnosed in you or any family member?		
Y	N	Ovarian cancer diagnosed in you or any family members?		
Y	N	Male breast cancer diagnosed in any family members?		
Y	N	Breast cancer diagnosed at 45 years of age or younger in you or any family members?		
Y	N	Bilateral breast cancer or multiple primary breast cancers diagnosed in you or any family members?		
Y	N	Three or more breast cancers diagnosed all on the same side of your family?		
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family?		

COLON AND UTERINE CANCER		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Colon cancer diagnosed before 50 years of age in you or any family members?		
Y	N	Uterine (Endometrial) cancer diagnosed before 50 years of age in you or any family members?		
Y	N	Two or more of the following cancers diagnosed all on the same side of your family (colon, uterine, ovarian, stomach, small Bowel, kidney/urinary tract, pancreatic, or brain)		

For Office Use Only

Patient offered genetic testing

Accepted

Declined

Reviewed By: _____

Patient Signature _____