HEALTH HISTORY

In order to obtain a comprehensive evaluation of your health, your doctor asks that you carefully complete this questionnaire. This form is intended to supplement your interview and is entirely confidential.

Thank you.

Today's Date ______________

Patient ____

Age ____________ **Date of last physical** ______________________

Occupation ____

Medications (please include vitamins and over the counter medications)

____

____

____

Medical illnesses (e.g. diabetes, cancer, heart/lung/liver disease, nervous and psychiatric disorders)

____

____

____

Surgeries/Hospitalizations (e.g. appendix, tonsils, hysterectomy, etc.)

____

____

____

Family History	Age/Age at death	Living?	Medical problems/Cause of death
Father	____________	Yes/No	___________________________
Mother	____________	Yes/No	___________________________
Brother/Sisters	____________	Yes/No	___________________________

Health maintenance (please indicate the year you had the following)

Pap smear ____________
Mammogram ____________
Colonoscopy ____________
Tetanus shot ____________

Dr. initial ________

PLEASE CHECK SYMPTOMS YOU CURRENTLY HAVE

YES	NO	
☐	☐	Weight Gain
☐	☐	Fever
☐	☐	Fatigue
☐	☐	Vision Change - Spots
☐	☐	Rash
☐	☐	Bleeding from gums
☐	☐	Headaches
☐	☐	Mouth Ulcers
☐	☐	Hearing Loss
☐	☐	Sinusitis
☐	☐	Chest Pain
☐	☐	Swelling
☐	☐	Palpitations
☐	☐	Difficulty breathing with activity
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Cough
☐	☐	Coughing up blood
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Gas
☐	☐	Blood in stool
☐	☐	Abdominal pain
☐	☐	Nausea - vomiting
☐	☐	Indigestion
☐	☐	Involuntary loss of stool - gas
☐	☐	Pain with intercourse

YES	NO	
☐	☐	Vaginal Discharge
☐	☐	Heavy Periods
☐	☐	Painful Periods
☐	☐	Vaginal Itching
☐	☐	Blood in Urine
☐	☐	Involuntary loss of Urine
☐	☐	Urgency or Pain With Urination
☐	☐	Muscle Pain
☐	☐	Muscle Weakness
☐	☐	Muscle Numbness
☐	☐	Seizures
☐	☐	Fainting Spells
☐	☐	Trouble Walking
☐	☐	Severe Memory Problems
☐	☐	Depression
☐	☐	Frequent Crying
☐	☐	Severe Anxiety
☐	☐	Hot Flashes
☐	☐	Hair Loss
☐	☐	Easy Bruising
☐	☐	Enlarged Lymph nodes
☐	☐	PMS

~PREGNANT PATIENTS~

Have you had the following:

YES	NO	
☐	☐	Bleeding
☐	☐	Spotting
☐	☐	Cramping

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
______________________								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

- ☐ Patient appropriate for further risk assessment and/or genetic testing
  - ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
  - ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
  - ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
  - ☐ MELARIS® – A test for Hereditary Melanoma
- ☐ Discussed hereditary cancer risk with patient
- ☐ Patient offered genetic testing
  - ☐ ACCEPTED ☐ DECLINED
- ☐ Follow up appointment scheduled
  - Date: ____________

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