CAPITAL WOMEN'S CARE DIVISION 43
NEW PATIENT QUESTIONNAIRE

NAME: _____ BIRTH DATE: _____ AGE: ____ HEIGHT: _____ TODAY'S DATE: _____

MARITAL STATUS (circle): Single Boyfriend Girlfriend Life Partner Married Separated Divorced Widow

OCCUPATION: _____ EMPLOYER: _____

REFERRED BY: _____ PRIMARY CARE PROVIDER: _____

WHAT PHARMACY DO YOU USE (name/address/phone #)? _____

REASON FOR VISIT: _____

CURRENT MEDICATIONS (include dose/frequency and over the counter):_____

_____

DRUG ALLERGIES (include reaction): _____

_____

HAVE YOU HAD ANY OF THESE IN YOUR MEDICAL HISTORY?			
	YES		YES
Hypertension		Hepatitis	
Heart Disease		HIV	
Murmur		Syphilis / Chlamydia / Gonorrhea / Trichomonas	
Stroke		Oral Herpes	
Blood Clots / DVT		Genital Herpes	
Bleeding Disorder		Genital Warts	
Anemia		Recurrent Vaginal Infections	
Blood Transfusion		Abnormal Pap Smear / HPV	
Elevated Lipids		Ovarian Cysts	
Diabetes		Uterine Fibroids	
Thyroid Disease		Endometriosis	
Anxiety		Polycystic Ovarian Syndrome	
Depression		Urinary Tract Infection	
Asthma / Lung Disease		Yeast Infection and/or Bacterial Vaginosis	
Kidney Disease		Pelvic Inflammatory Disease	
Bowel Problems		Infertility	
Bladder Disease		Back Problems	
Liver Disease		Broken Bones	
Jaundice		Skin Problems	
Glaucoma		Head Injury / Seizures	
Cataract		Migraines	
Cancer (type):		Other:	

SURGICAL HISTORY?			
	YES		YES
Appendectomy		Tumors	
Gallbladder		Breast	
Tonsils		Ovaries	
Hernia		Uterus	
Spine		C-Section	
Hemorrhoids		Other	
Kidney Stones			

GYNECOLOGIC HISTORY
First day of last period?
Age you started your menstrual cycle?
How many days does your period last?
How many days apart are your periods?
Average flow of your periods? Heavy Medium Light
Have you had all 3 HPV/Gardasil vaccines? Yes No
When was your last pap smear?
When was your last mammogram?
When was your last colonoscopy?
When was your last bone density scan?
Number of sexual partners in past 6 months?
What method(s) of birth control do you use?

FAMILY HISTORY		
	Relationship (state mom/dad's side?)	Deceased?
Diabetes		
Heart Attack		
High Cholesterol		
Migraine		
Stroke / High BP		
Bleeding Disorder		
Thyroid Disease		
Kidney Disease		
Emotional Problems		
Other (list cancers on back page)		

PREGNANCY HISTORY					
How many pregnancies have you had?					
How many live births have you had?					
How many living children do you have					
How many miscarriages have you had?					
How many terminations/abortions?					
YEAR	>37 weeks?	Gender	Weight	Vaginal or C-section?	Complications

Do you smoke tobacco? _____ How many packs per day? _____ For how many years? _____ Quit date? _____

Do you drink alcohol? _____ How many per week? _____ What type of alcohol? _____

Do you use illicit drugs? _____ If yes, what type of drug(s)? _____

Do you exercise? _____ If yes, what type of exercise? _____

Reviewed By: _____

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	-----	--	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE/ENDOMETRIAL CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐Y ☐N Are you of Ashkenazi Jewish descent?

☐Y ☐N Are you concerned about your personal and/or family history of cancer?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome* *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, either in one relative or in two or more relatives on the same side of the family
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome* *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐YES ☐NO ☐ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐YES ☐NO Date of Next Appointment: _____