Medical History

Name ______________________ Date of Birth ______________ Date __________

Family Doctor ______________________ Other doctors ______________________

If you are a new patient, whom may we thank for referring you to our practice? ______________________

Are you transferring care from another doctor, if so, from whom? ______________________

What is your main reason for your visit today? ______________________

What is your preferred pharmacy? (prescriptions will be sent to your pharmacy electronically) ______________________

GENERAL HISTORY

Please circle any of the following that apply to you:

High blood pressure	Stroke	Cancer	Ulcers
Heart disease	Blood clots	Breast	Irritable bowel syndrome
Heart attack	Bleeding disorder	Colon	Hepatitis
Heart murmur	Anemia	Ovarian	Migraines
Rheumatic fever	Asthma	Uterine	Seizure disorder
High cholesterol	Chronic lung disease	Other cancer______	Osteoporosis
Diabetes	Tuberculosis	Depression	Arthritis
Thyroid disease	Kidney disease	Anxiety	GERD

Other: ______________________

Physical or sexual abuse, past or present, can create serious physical or emotional problems for women. If this is an issue you would like to discuss, please indicate with a checkmark here ☐

SURGICAL HISTORY

Please circle any of the following that apply to you:

Hysterectomy	C-section: _____times	Tonsils removed	Other surgeries: _____
vaginal abdominal	Tubes tied	Appendix removed	______________
Ovaries removal	Breast surgery	Gallbladder removed	______________
left right both	Hernia repair	Heart surgery	______________
Ovarian cyst removed	Thyroid surgery	Tumor removed: ________	______________

GYNECOLOGIC HISTORY

Age at your first period ____ years

Period occurs every ___ days and last ___ days

Periods are: regular irregular

Date of last menstrual period ______________

Birth control method ______________

Date of last pap smear ______________

Was it normal? ______________

Please circle any of the following that apply to you:

Heavy periods	Genital warts	Breast problem	Painful sex
Severe cramping	Gonorrhea	Pelvic inflammatory disease	Hot flashes
Fibroids	Chlamydia	Tubal pregnancy	Night sweats
Ovarian cysts	Herpes	Pelvic pain	Bleeding after menopause
Abnormal pap smear	Other sexually transmitted disease ____________	Endometriosis	Urine leakage
Cryotherapy/LEEP		Infertility	Vaginal dryness
Memory loss	Decreased libido		

Other: ______________________

OBSTETRIC HISTORY

of pregnancies______ # full term births _____ # of preterm births ______ # of abortions/miscarriages _______

# of living children _______ Pregnancy complications, if any ______________________

Medication Allergies ☐ None ☐ ______________________

MEDICATIONS

Please include dose and frequency, including over the counter medications, vitamins, supplements and herbals

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

FAMILY HISTORY

Please include cancer, heart disease, diabetes, high blood pressure, blood clots and any other significant family history:

Mother: ______________________ Father: ______________________

Grandparents: ______________________ Sisters/Brothers: ______________________

______________________ ______________________

______________________ ______________________

SOCIAL HISTORY

Please circle: Single Married Divorced Widowed Same-sex relationship

Tobacco: ☐ None ☐ Former smoker ☐ Current smoker ___ packs per day

Alcohol: ☐ None ☐ Socially ☐ Other: ______________ Amount: ______ drinks per day

Drug use: ☐ None ☐ Former use ☐ Other: ______________________

Occupation: ______________________ Sexually active: Yes No

PREVENTIVE HEALTH HISTORY

Are your immunizations up-to-date?	Yes	No
Have you had the Hepatitis B vaccination series?	Yes	No
Have you had chicken pox or received the varicella vaccine?	Yes	No
Have you had a tetanus booster in the past 10 years?	Yes	No
Do you take calcium and vitamin D for your bones?	Yes	No
Do you take folic acid to prevent birth defects if you get pregnant?	Yes	No
Do you do self-breast examinations?	Yes	No
Did you complete the Gardasil (HPV Vaccine) series?	Yes	No

Last mammogram: ______________________

Last colonscopy: ______________________

Last bone density: ______________________

Last diabetes screening: ______________________

Last cholesterol screening : ______________________

Last thyroid screening: ______________________

Last pneumonia shot: ______________________

If you are in need of any vaccination updates, please indicate which ones here: ______________________

REVIEW OF SYSTEMS

Please circle any of the following that apply to you:

Constitutional: Fever Weight gain Weight loss Fatigue

Integumentary: Changes in moles Rashes Skin lesions

Breasts: Lumps Nipple discharge Skin changes Abnormal mammogram

Cardiovascular: Chest pain Swelling Valve disorders

Respiratory: Shortness of breath Wheezing Cough Bloody sputum

Gastrointestinal: Nausea Vomiting Bloating Diarrhea Constipation Blood in stool Black or tarry stool

Genitourinary: Burning or pain with urination Frequency Urgency Blood in urine Vaginal discharge Vaginal odor

Hematologic/Lymphatic: Blood clots Swollen lymph nodes Bruising easily

Endocrine: Excessive thirst Excessive hunger Excessive urination Hot flushes Cold intolerance Heat intolerance

Musculoskeletal: Joint pain Muscle pain Weakness

Neurological: Headaches Fainting Seizures

Psyciatric: Depression Anxiety Suicidal thoughts or plans

None of the above

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50			
Y	N	Colorectal cancer before age 50			
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer at age 50 or younger			
Y	N	Ovarian cancer			
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y	N	Male breast cancer			
Y	N	Triple negative breast cancer† (ER-, PR-, HER2- pathology)			
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?
If yes, please explain:

______________________ ______________
Patient's Signature Date

FOR OFFICE USE ONLY

☐ Candidate for further risk assessment and/or genetic testing: ☐ Lynch ☐ HBOC

☐ Information given to patient to review

☐ Follow-up appointment scheduled Date: ______________

☐ Patient offered genetic testing:
☐ Accepted
☐ Declined

______________________ ______________
Healthcare Professional's Signature Date

† For a better understanding of triple negative breast cancer, please ask your healthcare provider.
Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

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WHRA/12-11

DO NOT COPY

Brief Patient Health Questionnaire

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have.

Name ______________________ DOB __________ Sex: ☐ Female ☐ Male

Date: ______________

1. Over the last 2 weeks, how often have you been bothered by any of these problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself – or that you are a failure or that you have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have moving around more than usual	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.	**NO**	**YES**
a. In the last four weeks, have you had an anxiety attack – suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question # 3.		
b. Has this ever happened before?	☐	☐
c. Do some of these attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d. Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e. During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

FOR OFFICE CODING: Maj Dep Syn if answers to #1a or b and five or more of #1 a – I are at least "More than half the days" (count #1 if present at all). Other Dep Syn if #1 a or b and two three, or four of #1 a – I are at least "More than half the days" (count #1 if present at all.) Pan Syn if all of #2 a – e are "YES."

4. In the last 4 weeks, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	☐	☐	☐
b. Your weight or how you look	☐	☐	☐
c. Little or no sexual desire or pleasure during sex	☐	☐	☐
d. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	☐	☐	☐
e. The stress of taking care of children, parents, or other family members	☐	☐	☐
f. Stress at work outside of the home or at school	☐	☐	☐
g. Financial problems or worries	☐	☐	☐
h. Having no one to turn to when you have a problem	☐	☐	☐
i. Something bad that happened recently	☐	☐	☐
j. Thinking or dreaming about something terrible that happened to you in the past – like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? NO ☐ YES ☐

6. What is the most stressful thing in your life right now? ______________________________

____

7. Are you taking any medications for anxiety, depression or stress? NO ☐ YES ☐

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy and childbirth.

a. Which best describes you menstrual periods?

Periods are unchanged	No periods because pregnant or recently gave birth	Periods have become irregular or changed in frequency, duration or amount	No periods for at least a year	Having periods because taking hormone replacement (estrogen) therapy or oral contraceptive
☐	☐	☐	☐	☐

	NO (or does NOT apply)	YES
b. During the week before you period starts, do you have a serious problem with your mood – like depression, anxiety, irritability, anger or mood swings?	☐	☐
c. If YES: Do these problems go away by the end of your periods?	☐	☐
d. Have you given birth within the last 6 months?	☐	☐
e. Have you had a miscarriage in the last 6 months?	☐	☐
f. Are you having difficulty getting pregnant?	☐	☐