Center for Oncology
Cancer Genetics Risk Assessment
Health History Questionnaire

Contact Info:

Name: _____
First Middle Initial Last (Maiden)

Address: _____
Street

_____
City State Zip

Home Phone:( )_____ Work Phone:( )_____ Cell Phone: ( )_____

Email: _____

Preferred Contact: ☐ Home ☐ Work ☐ Other:_____ Best Time to Reach you: _____

Secondary Contact Info:

Name:_____ Relation:_____

Address:_____
Street

_____
City State Zip

Phone: ( )_____ Email:_____

Your Date of Birth: _____ **Today's Date:**_____

Current Marital Status: ☐ Married or living as married ☐ Separated
☐ Divorced ☐ Widowed
☐ Never married ☐ Other _____

Your Occupation:_____

Highest level of school you have completed:

☐ 8 years or less ☐ Some college or technical school
☐ Some high school ☐ Graduated college
☐ High school grad/GED ☐ Graduate or professional school

Race/Ethnicity

What is your, your mother's and your father's primary racial and ethnic background?

	Racial background	Ethnic background
Self		
Mother		
Father		

Racial Backgrounds: *White/Caucasian, Black/African American, Native American/Eskimo, Asian, Hawaiian/Pacific Islander, Hispanic/Latino*
Ethnic Backgrounds: *French, German, Russian etc.*

Are you, or is anyone in your family, **Jewish**? ☐No

☐Yes --> Who_____

☐ Ashkenazi, ☐ Sephardic, ☐ Unknown

Your Concerns

What is your primary reason for visiting the Cancer Genetics Risk Assessment Program?_____

_____

_____

_____

Are there any other concerns you would like addressed during your visit?_____

_____

_____

_____

Genetic Testing

Have you ever had genetic testing? ☐Yes ☐No

If yes, which gene(s) were tested?_____

Has anyone in your family had genetic testing that you are aware of? ☐Yes ☐No

If yes, which gene(s) were tested?_____

Has anyone in your family tested positive for a genetic mutation? ☐Yes ☐No

If yes, what mutation was discovered?_____

Where was the testing done?_____

Has anyone in the family been diagnosed with Falconi's anemia ☐Yes ☐No

If yes, who? _____

General Breast/Gynecologic History

Have you ever had a **mammogram**? ☐Yes ☐No

If yes, age at first Mammogram:_____ Date of last Mammogram:_____

Hospital/Location of last Mammo:_____

Date of last **physical breast exam**:_____

Have you ever had a breast **MRI**? ☐Yes ☐No

If yes, date of last breast MRI: _____

Hospital/Location of last MRI:_____

Do you have, or have you ever had, **breast implants**? ☐Yes ☐No

(This does NOT include breast reconstruction after mastectomy.)

Have you had one or both of your **breasts removed,** for reasons other than cancer treatment?
☐Yes ☐No
If yes, please complete the table below:

Breast Location (Left/Right/Both)	Date of Surgery	Hospital/Location	Reason
			☐Cancer Prevention ☐Other:
			☐Cancer Prevention ☐Other:

Have you had one or both of your **ovaries removed,** for reasons other than cancer treatment?
☐Yes ☐No
If yes, please complete the table below:

Location (Left/Right/Both)	Date of Surgery	Hospital/Location	Reason
			☐Cancer Prevention ☐Other:
			☐Cancer Prevention ☐Other:

Have you had your **uterus removed**? ☐Yes ☐No ☐Not Sure
If so, Date of Surgery:_____
Hospital/Location: _____

Date of Last **Pelvic Exam**:_____
Have you ever had an abnormality on a PAP smear? ☐Yes ☐No ☐Not Sure
If yes, what was the result?_____

Breast Biopsy History

Have you ever had a breast **biopsy**? ☐Yes ☐No ☐Not Sure

If yes, total number of breast biopsies you have had:_____

Benign Breast History

Have you ever been diagnosed with any of the **benign or non-cancerous breast conditions** listed below?
☐Yes ☐No ☐Not Sure

If Yes, which condition(s) were you diagnosed with? *(Check all that apply)*

☐ Atypical Hyperplasia ☐ Hyperplasia ☐ Mastitis
☐ Fat Necrosis ☐ LCIS ☐ Other _____
☐ Fibroadenoma ☐ Lipoma ☐ Indeterminate diagnosis
☐ Fibrocystic Disease ☐ Mammary Duct Ectasia ☐ I am uncertain

For each condition, please provide the following information about surgery you have had:

Breast Condition	Breast Location (Left/Right)	Date of Surgery/Biopsy	Hospital/Location

General Hormone Use

Contraceptives

Have you ever used contraceptive pills, injections (Depo-Provera), or implants (Norplant) to prevent pregnancy or for any other reason? ☐Yes ☐No

If yes, please complete the table below:

Month/Year Began	Age Began	Month/Year Stopped	Age Stopped

Fertility

Have you ever had a problem with infertility? ☐Yes ☐No

Have you ever taken infertility medication? ☐Yes ☐No

If yes, please complete the table below:

Hormone Name	Month/Year Began	Age Began	Month/Year Stopped	Age Stopped

Hormone Replacement Therapy (HRT)

Have you ever taken HRT? ☐Yes ☐No

If so, what did you take? ☐Estrogen alone
(refer to table to the right) ☐Estrogen and Progestin
☐Estrogen and Testosterone
☐Not sure

Estrogen	Estrogen + Progestin	Estrogen + Testosterone
Premarin	Prempro	Estratest
Estradiol	Premphase	

Month/Year Began	Age Began	Month/Year Stopped	Age Stopped

Breast Cancer Prevention

Have you ever taken Tamoxifen (Nolvadex) or Raloxifene (Evista)? ☐Yes ☐No

If yes, please complete the table below:

Hormone Name	Month/Year Began	Age Began	Month/Year Stopped	Age Stopped	Reason
					☐Cancer Prevention ☐Cancer Treatment ☐Other
					☐Cancer Prevention ☐Cancer Treatment ☐Other

Menstrual History

Age at First Menstrual Period: _____

Have you had a menstrual period within the last year? ☐Yes

☐No --> Age at last menstrual period:_____

Cause of Menopause: ☐ natural
☐ chemotherapy, medication induced
☐ surgery on reproductive organs ☐ other:_____

Pregnancies

Have you ever been pregnant? ☐Yes ☐No

If yes, please fill out the chart below

		Outcome				Breast Feeding	
Pregnancy	**Date of End of Pregnancy**	***Live birth***	***Still born***	***Miscarriage***	***Induced abortion***	**Yes/No**	**Months of breast feeding**
1							
2							
3							
4							
5							
6							
7							
8							
9							

Your age at first birth:_____

Smoking History

Have you ever smoked cigarettes?
(at least 1 pack per month for 1 year) ☐Yes ☐No

If yes: What age did you start smoking regularly?_____
Do you still smoke? ☐Yes ☐No
If no, what age did you stop? _____
How many total years did you smoke (excluding periods of non-smoking)?_____
On average, how many packs did you smoke per day? _____
(1 pack = 20 cigarettes)

Alcohol

How many drinks per week on average do you have currently? _____

What type of alcohol is it typically (beer, wine, etc.)? _____

Exercise: *Please describe any exercise that you do regularly, how often and for how long*

_____

_____

Current Medications

Do you take any medications regularly? ☐Yes ☐No *Please list names of medications here:*_____

_____

_____

_____

Current Cancer Screening

Are you getting a cancer screening on a routine basis (such as ultrasound, colonoscopy, CA-125, PSA, breast exam, mammogram, skin check-up? ☐Yes ☐No

If yes, please describe in the table below:

Type of Screening Exam	How often	Month/Year of Last Exam
	☐Every year ☐Every 5 years ☐Other:	
	☐Every year ☐Every 5 years ☐Other:	
	☐Every year ☐Every 5 years ☐Other:	

Other Health Problems

Please check all that apply.

Medical Condition	Never had this condition	Had it more than 12 months ago	Had it within past 12 months
Arthritis/Rheumatism	☐	☐	☐
Blood Clots (lungs, legs)	☐	☐	☐
Colitis (inflammatory bowel, Crohn's)	☐	☐	☐
Colon Polyps	☐	☐	☐
Diabetes	☐	☐	☐
Eye Problems (cataracts, glaucoma etc.)	☐	☐	☐
Endometriosis	☐	☐	☐
Heart Problems	☐	☐	☐
High Blood Pressure	☐	☐	☐
Kidney Problems	☐	☐	☐
Osteoporosis (bone loss, thinning)	☐	☐	☐
Ovarian Cyst	☐	☐	☐
Stroke	☐	☐	☐
Vaginal Bleeding, abnormal	☐	☐	☐

Have you ever had a **bone density** (DEXA) scan? ☐Yes ☐No

If yes, what was the date of your last scan?_____

Where was the scan done?_____

Cancer History

Have you ever had cancer? ☐Yes ☐No ***(please also include skin cancers)***
If so, please complete the following chart:

Cancer Site/Type:	**Your 1st cancer**	**Your 2nd cancer**
Location (Left/Right/Not Applicable)		
Date of Diagnosis		
Age of Diagnosis		
Did you have **Surgery** for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Name of Procedure		
Surgery Date		
Treatment Hospital		
Did you receive **Chemotherapy** for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Type of Chemo* (Please choose from list below)		
Treatment Hospital		
Did you receive **Radiation** for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
Treatment Hospital		
Did you receive **Hormonal Therapy** for this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Name of Hormone (ex. Tamoxifen)		
Did you receive any **other** type(s) of therapy?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Please specify.		
Have you had a **Recurrence** with this Cancer?	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: When?		
Where did this cancer recur? (ex. lung, breast, liver)		

***Chemo Drug List**

Adriamycin
Cytoxan
Fluorouracil
Leucovorin
Methotrexate
Paclitaxel
Taxol
Taxotere
Other

Other Surgeries

Have you had any other surgeries? ☐Yes ☐No If yes, please describe: _____

_____

_____