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MEDICAL HISTORY QUESTIONNAIRE

Date: __________   Patient Name: ____   DOB: _____________   Age: ____

Please **CIRCLE** any of the conditions that you are experiencing **TODAY**.

GENERAL/SYSTEMIC:
- ☐ Feeling tired
- ☐ General edema
- ☐ Chills
- ☐ Night sweats
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Difficulty falling asleep
- ☐ Snoring
- ☐ Daytime sleepiness

EYES:
- ☐ Vision problems
- ☐ Blurry vision

EAR/NOSE/THROAT
- ☐ Ringing in the ears (tinnitus)
- ☐ Loss of hearing
- ☐ Sinus pressure
- ☐ Nosebleeds recurrent
- ☐ Mouth sores
- ☐ Bleeding gums
- ☐ Hoarseness
- ☐ Difficulty swallowing (dysphagia)

NECK:
- ☐ Lump or swelling in the neck

BREAST:
- ☐ Breast pain
- ☐ Breast lump
- ☐ Nipple discharge

CARDIOVASCULAR:
- ☐ Chest pain or discomfort
- ☐ Palpitations

PULMONARY:
- ☐ Cough
- ☐ Coughing up blood (hemoptysis)
- ☐ Shortness of breath
- ☐ Wheezing

GASTROINTESTINAL:
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black or tarry stools (melena)

GENITOURINARY
- ☐ Incomplete emptying of the bladder
- ☐ Pain during urination (dysuria)
- ☐ Urinary frequency
- ☐ Urinary loss of control
- ☐ Pelvic pain
- ☐ Vaginal discharge
- ☐ Bloody or dark urine

ENDOCRINE:
- ☐ Excessive thirst
- ☐ Temperature intolerance to heat
- ☐ Temperature intolerance to cold

SKIN:
- ☐ Skin rash
- ☐ Itching (pruritus)
- ☐ Skin lesion

HEMATOLOGICAL:
- ☐ Easy bleeding

MUSCULOSKELETAL:
- ☐ Diffuse joint pain (arthralgias)
- ☐ Back pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐

NEUROLOGOCAL:
- ☐ Numbness (hypoesthesia)
- ☐ Tingling
- ☐ Dizziness
- ☐ Headache
- ☐ Vertigo
- ☐ Tremors
- ☐ Fainting (syncope)
- ☐ Seizure
- ☐ Feeling weak

PSYCHOLOGICAL:
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep disturbances
- ☐ Suicidal ideation
- ☐ Cry often
- ☐ Highly irritable
- ☐ Tense or under stress

DEPRESSION
- ☐ Depression recently
- ☐ Depression chronic

SEXUAL
- ☐ Libido changes
- ☐ Unsatisfactory sexual interest
- ☐ Painful intercourse
  - ○ Entry
  - ○ Vagina
  - ○ Deep
  - ○ Other

GYNECOLOGY:
- ☐ Vaginal odor
- ☐ Vaginal itching or burning

☐ **ALL OTHERS NEGATIVE**

NAME		DATE OF BIRTH	AGE	DATE OF SERVICE
PCP	**REFERRED BY**		**PHARMACY**	
CC/HPI				

REVIEW OF SYSTEMS - SEE SEPARATE FORM

MEDICAL HISTORY	**Yes**	**No**		**Yes**	**No**
Blood clots (leg/lungs)	[ ]	[ ]	Urinary tract infection	[ ]	[ ]
Stroke	[ ]	[ ]	High cholesterol	[ ]	[ ]
Headaches / migraines	[ ]	[ ]	Depression / anxiety	[ ]	[ ]
High blood pressure	[ ]	[ ]	Osteoporosis / osteopenia	[ ]	[ ]
Diabetes	[ ]	[ ]	Arthritis	[ ]	[ ]
Cancer: (type)	[ ]	[ ]	Asthma / lung disease	[ ]	[ ]
Thyroid disease	[ ]	[ ]	Breast disease	[ ]	[ ]
Heart disease / murmur	[ ]	[ ]	Blood disorders / anemia	[ ]	[ ]
Jaundice / hepatitis	[ ]	[ ]	Transfusion	[ ]	[ ]
Digestive / bowel disorders	[ ]	[ ]	Neurologic disorder	[ ]	[ ]
Gallbladder disease	[ ]	[ ]	Skin disease	[ ]	[ ]
Kidney disease	[ ]	[ ]	Other	[ ]	[ ]

SURGICAL HISTORY

Year	Procedure	Year	Procedure

GYNECOLOGIC HISTORY	**Yes**	**No**
Any abnormal PAP smear?	[ ]	[ ]
Treatment for cervical dysplasia?	[ ]	[ ]
DES exposure?	[ ]	[ ]
Sexually transmitted infections?	[ ]	[ ]

Circle: chlamydia; gonorrhea; syphilis; herpes; HPV: genital warts; HIV; Hepatitis B; trichamonas

MENOPAUSAL

Age of first period? ___________
Age of last period? ___________
Do you take hormones? ___________
Have you used hormones in the past? ___________
Do you have vaginal bleeding? ___________

PREGNANCY HISTORY

Number of pregnancies ___________
Number of living children ___________
Number of term deliveries ___________

MENSTRUATING (if menopausal, omit)

First day of last period? ___________
Age of first period? ___________
How often do you bleed? ___________
How many days do you flow? ___________
Do you spot between periods? ___________
Are periods painful? ___________
Are periods heavy? ___________
Do you use any kind of birth control? ___________
Type of birth control? ___________

Reviewed by ___________ Date___________
Done: JB___________ ALM ___________ MA___________ Date ___________

PREGNANCY HISTORY

Number of pre-term deliveries (more than 3 weeks early)
Number of adopted children
Number of miscarriages / abortions
Number of tubal pregnancies (ectopic)

LIFE STYLE

Do you exercise?	Yes [ ] No [ ]	Frequency?	Type?
Do you take a calcium supplement?	Yes [ ] No [ ]	How much? ________________________	
Do you take a vitamin D supplement?	Yes [ ] No [ ]	How much? ________________________	
Do you drink alcohol?	Yes [ ] No [ ]	How much? ________________________	
Do you smoke?	Yes [ ] No [ ]	How much? ________________________	
Have you ever smoked?	Yes [ ] No [ ]	How much? ________________________	
Have you ever used IV drugs?	Yes [ ] No [ ]		
Are you currently in a sexual relationship?	Yes [ ] No [ ]		
Number of sexual partners ever?			
Have you changed sexual partners in the last 5 years?	Yes [ ] No [ ]		
Is your sexual partner male or female?	Male [ ] Female [ ]		

SOCIAL HISTORY	**Yes**	**No**
Do you work outside the home?	[ ]	[ ]
Is anyone hurting you?	[ ]	[ ]
Has anyone ever sexually violated you?	[ ]	[ ]

HEALTH MAINTENANCE

Last mammogram?	Year __________	Tetanus / pertussis	Year __________
Last PAP smear?	Year __________	Shingles	Year __________
Last cholesterol test?	Year __________	Pneumovax	Year __________
Colorectal cancer screening? (if >50 years old)	Year __________	Meningococcal	Year __________
Stool blood test?	Year __________	Hepatitis B	
Colonoscopy?	Year __________	Year: #1 _______ #2 _______ #3 ______	
Bone density study?	Year __________	HPV	
Pneumococcal vaccine?	Year __________	Year: #1 _______ #2 _______ #3 ______	
Tetanus booster?	Year __________		

FAMILY HISTORY	**Yes**	**No**	Type (organ)?	Who?
Cancer?	[ ]	[ ]	______________	______________________________
	[ ]	[ ]	______________	______________________________
	[ ]	[ ]	______________	______________________________

			Who?
Heart disease?	[ ]	[ ]	____
Diabetes?	[ ]	[ ]	____
High blood pressure?	[ ]	[ ]	____
Osteoporosis	[ ]	[ ]	____
Stroke?	[ ]	[ ]	____
Blood clots in legs / lungs?	[ ]	[ ]	____
Thyroid disease?	[ ]	[ ]	____
Drug / alcohol abuse?	[ ]	[ ]	____
Mental disorders?	[ ]	[ ]	____
Other?	[ ]	[ ]	____
	[ ]	[ ]	____

MEDS / ALLERGIES - see problem list

Cancer History Questionnaire

Name: ____________________ **Date of Birth:** ____________________

Gender: ____________ **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 Maternal Side	Age of Diagnosis	Relatives Paternal Side	Age of Diagnosis
☐ Y ☐ N	***Example: Breast Cancer***	***45***	------	------	***Aunt*** ***Cousin***	***45*** ***61***	***Grandmother***	***53***
☐ Y ☐ N	Breast cancer *(Female or Male)*							
☐ Y ☐ N	Ovarian cancer *(Peritoneal/Fallopian tube)*							
☐ Y ☐ N	Endometrial (*Uterine*) cancer							
☐ Y ☐ N	Colon/rectal cancer							
☐ Y ☐ N	10 or more Lifetime Colon/Rectal Polyps *(Specify #)*							
☐ Y ☐ N	Pancreatic cancer							
☐ Y ☐ N	Prostate cancer							
☐ Y ☐ N	Other Cancer(s) *(Specify cancer type)*							

Are you of Ashkenazi Jewish descent? (circle one) YES NO

Are you concerned about your personal and/or family history of cancer? (circle one) YES NO

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

If Yes, Who? ____________ What gene(s)? ____________ What was the result? ____________

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) ______ **Your current weight** (lbs) ______

Your menopausal status:

☐ Pre-menopausal

☐ Peri-menopausal (time before menopause marked by irregular cycles)

☐ Post-menopausal: Age of onset ______
(Permanent cessation of period for 12 months or longer)

Your age at time of first menstrual period ______

Your age at time of first live birth ______

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ unknown

If yes, are you a: ☐ Current user: How many years ago did you start?

Intend to use for ______ more years

☐ Past user: How many years ago did you stop using? ______

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? ____________

Number of daughters ______ **Number of sisters** ______

Number of maternal aunts (mother's sisters) ______

Number of paternal aunts (father's sisters) ______

HEREDITARY CANCER RED FLAGS (COMPLETE WITH YOUR HEALTH CARE PROVIDER)

Personal and/or family history of any one of the following

(check all that apply)

MULTIPLE: A combination of cancers on the same side of the family:

☐ **2 or more:** breast / ovarian / prostate / pancreatic cancer

☐ **2 or more:** colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)

☐ **2 or more:** melanoma / pancreatic

YOUNG: Any 1 of the following at age **50 or younger:**

☐ Breast cancer ☐ Colon/rectal cancer ☐ Endometrial cancer

RARE: Any 1 of these rare presentations at **any age:**

☐ Ovarian cancer (Peritoneal/Fallopian tube)

☐ Breast: Male breast cancer or Triple negative breast cancer (ER-, PR-, HER2- Pathology)
Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology††

☐ Endometrial cancer with abnormal MSI/IHC

☐ 10 or more colon/rectal polyps*

Certain ancestries such as Ashkenazi Jewish, may have greater risk for hereditary cancer syndromes

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature	Date