PATIENT HISTORY FORM

Name: _____ Birthdate: _____

Address: _____ City/St/Zip _____

Cell Phone: _____ Home Phone: _____

Email: _____

Primary Care Physician/Address: _____

Local Pharmacy: _____ Mail order Pharmacy: _____

MEDICATIONS

(Including any vitamins or over the counter medication)

Medication Dose Reason Taking Prescribed by: _____

_____

_____

_____

_____

*Attach additional sheet if needed

WHEN WAS YOUR LAST FLU SHOT: _____

Consent is given to document this immunization history to the registry ☑ (**please check**)

ALLERGIES

_____ _____

_____

SOCIAL HISTORY

Alcohol/Amount _____ Caffeine/ Amount _____ Smoking/Amount_____
Age Started_____

PAST SURGICAL HISTORY

Please list any surgeries and approximate dates: _____

_____

_____

_____

*Attach additional sheet if needed

PAST MEDICAL HISTORY

Cardiovascular

Blood Clot (DVT)_____ Congestive Heart Failure _____ Heart Disease _____
High Cholesterol _____ Hypertension _____ TIA/Stroke_____
Mitral Valve Prolapse_____

OB History

Pregnancies _____ Living_____ Missed Ab_____ Delivered: (Vaginal or C-Section)_____
Gestational age-weeks _____ High Blood Pressure_____ Gestational Diabetes_____
Other Pregnancy Problems_____

GYN History

Last Pap Smear_____ Abnormal Pap Smear/Dysplasia_____ HPV_____
Chlamydia_____ Gonorrhea_____ Herpes/Type_____
PID_____ Contraception_____ Premature Menopause_____
Polycystic Ovaries _____ Post Menopausal Bleeding _____ Endometriosis _____
Fibroid Tumors_____ Hormone Replacement Therapy _____
Age Periods Started _____ Hysterectomy/ Type _____

Breast History

Last Mammogram_____ Fibrocystic Breast _____ Breast Lump _____
Other (Please Specify) _____ _____

Cancer History

Breast Cancer_____ Uterine Cancer _____ Cervical Cancer_____
Other Cancer (Please Specify)_____

Digestive History

Crohn's Disease _____ Peptic Ulcer _____ Irritable Bowel Syndrome_____
Other (Please Specify) _____

Endocrine/ Metabolic History

Anorexia _____ Hypothyroid_____ Obesity_____
Grave's Disease_____ Chronic Fatigue Syndrome_____ Diabetes (Type I or II)_____
Other (Please Specify) _____

Musculoskeletal History

Arthritis _____ Fibromyalgia _____ Osteoporosis _____
Osteopenia _____ Other (Please Specify) _____

Neurologic History

Epilepsy _____ Migraines_____ Other (Please Specify) _____

Psychiatric History

Anxiety Disorder _____ Depression _____ Bipolar Disorder _____
Panic Disorder _____ Obsessive Compulsive Disorder _____
Other (Please Specify) _____

Blood/Hematologic History

Anemia _____ Clotting Disorder _____ Sickle Cell Trait _____
Other Blood Disorder (Please Specify) _____

Urology History

Kidney Stones _____ Renal Failure _____ Other (Please Specify) _____

Infection History

Hepatitis/Type _____ HIV _____ Other (Please Specify) _____

Patient Signature: _____ **Date**: _____

Parent/Guardian Signature: _____ (if patient under age 18)

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Family History (**M**other, **F**ather, **S**ister, **B**rother/ **MGM-**Maternal Grandmother, **MGF-** Maternal Grandfather, **PGM**-Paternal Grandmother, **PGF-** Paternal Grandfather, **U**ncle, **A**unt)

Breast Cancer_____ Uterine Cancer _____ Ovarian Cancer _____
Colon Cancer _____ Lung Cancer _____ Pulmonary Emboli _____
High Blood Pressure _____ High Cholesterol _____
Obesity _____ Hypothyroid _____
Endometriosis _____ Diabetes I_____II _____
Other (Please Specify) _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) or (No) next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

Blood relatives should be considered: *You, Parents, Brothers, sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, and First-Cousins.* ***AGE IS VERY IMPORTANT***

	CANCER	SELF	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
□ Y □ N	Have you or any relatives been diagnosed with breast cancer under the age of 50?					
□ Y □ N	Do you have two or more relatives on the same side of the family diagnosed with breast cancer? (Please list who/ages)?					
□ Y □ N	Have you or any relatives been diagnosed with ovarian cancer at any age?					
□ Y □ N	Any male breast cancer diagnosed at any age?					
□ Y □ N	Any uterine cancer before age 50? (not cervical)					
□ Y □ N	Any colon or rectal cancer before the age of 50?					

Are you of Jewish (Ashkenazi decent)? _____**yes** _____**no**

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY

☐ Literature given for risk assessment and/ or genetic testing.
☐ Patient desires _____ Patient declines _____ Patient not appropriate for testing _____
☐ Follow up appointment in 5-6 weeks
☐ I acknowledge that I have been fully advised by my doctor that my refusal to be tested may delay or prevent diagnosis/treatment of cancer and have an increased risk of serious disease or death.

Physician Signature: _____ Date: _____

(Rev 01/2015)