PATIENT INITIATED HISTORY

Name: ______________________________

Current health problems/concerns: Mark [**C**] for current problems.
Mark [**X**] to indicate if you had these problems in the past.

NECK
___ Goiter
___ Lump
___ Pain or stiffness

BREAST
___ Lump
___ Discharge
___ Pain

NEUROLOGICAL
___ Frequent headaches
___ Convulsions
___ Depression or anxiety
___ Other ____________

HEART AND LUNGS
___ Chronic cough
___ Shortness of breath
___ Night sweats
___ Chest pain or pressure
___ Palpitation or fluttering
___ Swollen ankles

EXTREMITIES
___ Arthritis, joint pain
___ Varicose veins
___ Cramps in legs
___ Blood clots
___ Swollen lymph nodes

INTESTINAL
___ Loss of appetite
___ Swelling
___ Nausea or vomiting
___ Vomiting of blood
___ Pain in abdomen
___ Gallbladder trouble
___ Change in bowel habits
___ Constipation
___ Diarrhea
___ Blood in stools
___ Black, tarry stools

KIDNEY, BLADDER & GENITALS
___ Albumin or sugar in urine
___ Blood or pus in urine
___ Kidney or bladder infection
___ Getting up at night to urinate (____ times)
___ Vaginal discharge
___ Urine leakage

MENSTRUATION
Age of onset of period ____
Date of last period ____
Bleeding between periods ____
Number of pregnancies ____
Year of menopause ____

PAST HISTORY
Please list with approximate dates
Major illnesses ______________________
Operations ______________________

FAMILY HISTORY OF DISEASE
(i.e. cancer, high blood pressure, diabetes)
Mother ______________________
Father ______________________
Siblings ______________________
Children ______________________

SOCIAL HISTORY
Please complete the following:
I live with ______________________
Marital status ______________________
Occupation ______________________
Do you smoke? ☐ YES ☐ NO
Do you drink? ☐ YES ☐ NO
Do you use drugs? ☐ YES ☐ NO

ALLERGIES ______________________

MEDICATIONS ______________________

Please place a check mark (✓) in the boxes below for yourself and for each family member who has had cancer diagnosed as indicated.

	BREAST CANCER Before Age 50	OVARIAN CANCER At any age	COLON CANCER Before age 50	COLON CANCER After age 50	ENDOMETRIAL CANCER Before age 50	ENDOMETRIAL CANCER After age 50	OTHER CANCERS AT ANY AGE Ovarian, gastric, kidney/urinary tract, gall-bladder, central nervous system, small bowel
FIRST DEGREE RELATIVES							
Yourself							
Mother							
Sister(s)							
Daughter(s)							
MOTHER'S SIDE							
Grandmother							
Aunt(s)							
Cousin(s)							
FATHER'S SIDE							
Grandmother							
Aunt(s)							
Cousin(s)							

Ask your provider to evaluate your risk for hereditary breast and ovarian cancer if you have
- Two (2) or more check marks (✓) in the above table **OR**
- One (1) check mark (✓) in the above table and you are of Ashkenazi Jewish descent, **OR**
- Any male relatives with breast cancer at any age.

Ask your provider to evaluate your risk for HNPCC if you have a personal or family history of:
- Colon or endometrial cancer diagnosed before age 50 **OR**
- Two (2) first degree relatives with colon or endometrial cancer diagnosed at any age, **OR**
- Two (2) or more tumors in the same individual (two colon cancers or colon and endometrial cancer)