Name: ______________________________ DOB: ______________

Medical & Surgical History

Obstetric History

Number of Live Births ________ Number of Abortions ________
Number of Miscarriages ________ Number of Children Living ________

Date	Method of Delivery (vaginal, cesarean, vacuum, forceps)	Weight of Infant	Sex / Name of infant	Complications
Sample:				
10/2001	Vaginal	7lbs 2 oz	Female / Lucy	Diabetes

Gynecologic History

(Please fill out only 1 column.)

Still Menstruating? Answer the following questions:		Postmenopausal? Answer the following questions:	
Your age when you had your first period?	____	Your age when you had your first period?	____
When was your Last period?	____	When was your last period?	____
When was your Last Pap smear?	____	When was your Last Pap smear?	____
Was it normal?	Y / N	Was it normal?	Y / N
Have you ever had an abnormal Pap?	Y / N	Have you ever had an abnormal Pap?	Y / N
Have you had a STD?	Y / N	Have you ever taken any hormones?	Y / N
If yes, which ones? ________________		If so, what and when? ________________	
Are you sexually active?	Y / N	Are you sexually active?	Y / N
Are you using contraception?	Y / N	Do you have sex with men, women or both?	____
If yes, which type? ________________		Have you had your uterus removed?	Y / N
Do you have sex with men, women or both?	____	Have you had your ovaries removed?	Y / N
Do you experience any of the following?		Have you had any vaginal surgeries?	Y / N
Heavy menses?	Y / N	Do you experience any of the following?	
Bleeding between periods?	Y / N	Postmenopausal bleeding?	Y / N
Painful menses?	Y / N	Urinary or fecal incontinence?	Y / N
Pain with intercourse?	Y / N	"Falling" of pelvic organs?	Y / N
Bleeding after intercourse?	Y / N	Low Libido	Y / N

Family Planning

What are you plans for having Children? (Select your answer from below and circle it.)

Never In ___years I have finished childbearing I am trying now Uncertain

Physician Signature ____________________

Date ________

Name: ______________________________ DOB: ____________

Medical History			
Medical Condition	Name of Medication	Dose & how often you take it	When did you start this medication?
Sample:			
1. High blood pressure	Lisinopril	10 mg, 1 daily	2001
Comments: Managed by Dr. Smith			
1.			
Comments:			
2.			
Comments:			
3.			
Comments:			
4.			
Comments:			
5.			
Comments:			
6.			
Comments:			
7.			
Comments:			
8.			
Comments:			

I do not have any medical conditions. _____

Surgical and Hospitalization History		
Date	Surgery, Serious Injuries or Reason for Hospitalization	Comments
Samples:		
3/2001	Breast Biopsy	Benign fibroma
4/2002	Motor Vehicle Accident – pelvic fracture	Blood clot in hospital

I have never had surgery or been hospitalized. _____

Physician Signature ____________________

Date __________

Name: ______________________ DOB: __________

Family History

Please see Separate Sheet for Hereditary Cancer Syndromes

Family Member	Illness	Living / Deceased
Sample: Mother	Diabetes	Deceased age 73

I was adopted and do not know my family history. _____

No one in my family has any medical problems. _____

Social History

Marital Status (please circle one): Single Married Widowed Divorced Separated

Partner's name: ______________________

Highest Level of Education: ______________________

Employer and Job Title: ______________________

Race (please circle one): Caucasian Hispanic African American Asian American Native American Other: ________

Ethnicity (please circle one): Latino Jewish Arabic Refused Other: ________

Do you currently smoke?	☐ Yes ☐ No	If yes, how many Packs per day?	For how many years?
Have you ever smoked?	☐ Yes ☐ No	If yes, how many packs per day?	For how many years?
Do you drink alcohol?	☐ Yes ☐ No	If yes, how many drinks per week?	
Do you use illegal drugs?	☐ Yes ☐ No	If yes, which ones?	
Do you use medical marijuana?	☐ Yes ☐ No	If yes, how much?	

Review of Systems

Please check next to any conditions you have had or have currently.

Constitutional: Weight change	☐	**ENT:** Mouth ulcers	☐	**GI:** Nausea / vomiting	☐
Fatigue	☐	Upper respiratory infection	☐	Diarrhea	☐
Eyes: Vision changes	☐	**Cardiovascular:** Chest pain	☐	Bloody stools	☐
Cataracts	☐	Difficulty breathing when lying down	☐	Constipation	☐
Glaucoma	☐	Difficulty breathing on exertion	☐	**Psychiatric:** Depression	☐
Musculoskeletal: Weakness	☐	**Hematologic:** Easy bruising	☐	Anxiety	☐
Skin: Rash	☐	Easy bleeding (gums or nose bleeds)	☐	**Endocrine:** Hot flashes	☐
Neurological: Seizure	☐	Adenopathy (swollen glands)	☐	Diabetes	☐
Syncope (fainting)	☐	**Immunologic:** Seasonal allergies	☐	Thyroid problems	☐
Headache	☐	Food allergies	☐	**Respiratory:** Short of breath	☐

Physician Signature ______________________

Date __________

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date Completed: ______________________ Date of Birth: ______________________

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	*none*	—	*Brother*	*36 yrs*	*Aunt Cousin*	*44 yrs 58 yrs*	*Grandfather*	*65 yrs*
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
______________________								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________

FOR OFFICE USE ONLY	
☐ Patient appropriate for further risk assessment and/or genetic testing ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer Syndrome ☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) ☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes ☐ MELARIS® – A test for Hereditary Melanoma	☐ Discussed hereditary cancer risk with patient ☐ Patient offered genetic testing ☐ ACCEPTED ☐ DECLINED ☐ Follow up appointment scheduled Date: ______________

Myriad, the Myriad logo, BRAC*Analysis*, COLARIS, COLARIS *AP*, and MELARIS are either trademarks or registered trademarks of Myriad Genetics, Inc., in the United States and other jurisdictions. ©2010, Myriad Genetic Laboratories, Inc.