



## CANCER GENETIC RISK ASSESSMENT PROGRAM MEDICAL HISTORY QUESTIONNAIRE

Please complete this form to the best of your ability. Feel free to add additional information/comments at the back of the form. Please fax back to (415) 600-5975, or mail to Cancer Genetic Risk Assessment Program, California Pacific Medical Center – Pacific Campus, 2351 Clay St, Stanford Bldg, Ste 513C, San Francisco, CA 94115. If you have questions, please call (415) 600-5961, and we will be happy to assist you.

### DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_  
Last First M.I.

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

Day Ph: \_\_\_\_\_ Eve Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Family MD: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Your major concerns/reason for visit: \_\_\_\_\_

### INSURANCE INFORMATION

Insured's Name: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

GroupName: \_\_\_\_\_ Group #: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Member Services Phone #: \_\_\_\_\_

### OFFICE USE ONLY

Appointment Date: \_\_\_\_\_ Appointment Time: \_\_\_\_\_

GC: \_\_\_\_\_ Location: \_\_\_\_\_

Packet Received: \_\_\_\_\_ Auth. For Appt. Completed: \_\_\_\_\_

### REFERRAL INDICATION

**LIFESTYLE**

Marital Status: \_\_\_\_\_ Partner's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Your Ethnicity: \_\_\_\_\_ Your Partner's Ethnicity: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Your Partner's Occupation: \_\_\_\_\_

Dietary fat intake: *High Medium Low* Regular Exercise Routine: *Yes No*

Smoker: *Yes No* Alcohol Consumption: *>2 drinks/day 1-2 drinks/day occasional never*

Comments: \_\_\_\_\_

**REPRODUCTIVE HISTORY**

1<sup>st</sup> menstrual cycle at: \_\_\_\_\_ Menopause Age: \_\_\_\_\_ *Natural or Surgical*

Birth control pills (start date, end date): \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of biological children: \_\_\_\_\_ Age at first pregnancy: \_\_\_\_\_

Hysterectomy: *No Complete Partial* HRT: *Yes No* Start Date \_\_\_\_\_

**CANCER SCREENING/DIAGNOSIS HISTORY**

Breast Self Exam: *Yes No* How often? \_\_\_\_\_

Clinical Breast Exam: *Yes No* How often? \_\_\_\_\_

Mammograms: *Yes No* Age at 1<sup>st</sup> \_\_\_\_\_ Date of Most Recent \_\_\_\_\_ Frequency \_\_\_\_\_

Breast Ultrasound: *Yes No* Age at 1<sup>st</sup> \_\_\_\_\_ Date of Most Recent \_\_\_\_\_ Frequency \_\_\_\_\_

If any of the above were ever abnormal, please explain \_\_\_\_\_

Breast Biopsies: *Yes No*

Date: \_\_\_\_\_ Site: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Date: \_\_\_\_\_ Site: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

CA-125: *Yes No* Transvaginal Pelvic U/S: *Yes No* Date of Most Recent \_\_\_\_\_

Sigmoidoscopy/Colonoscopy: Age at 1<sup>st</sup> \_\_\_\_\_ Date of Most Recent \_\_\_\_\_ Frequency \_\_\_\_\_

Result/ Diagnosis \_\_\_\_\_

Colon Polyps: *Yes No*

Date: \_\_\_\_\_ # of polyps: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Date: \_\_\_\_\_ # of polyps: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

**OTHER SCREENING:**

If you have had other screening (including prostate), please explain \_\_\_\_\_

Have you ever been diagnosed with cancer? *Yes No*

If YES, please send us a copy of the pathology/ oncologist report as well from each diagnosis

1) Type: \_\_\_\_\_ Location of tumor: \_\_\_\_\_ Age at Diagnosis \_\_\_\_\_

Surgery: \_\_\_\_\_ Chemotherapy: \_\_\_\_\_ Radiation: *Yes No*

Hospital/ Doctor/ contact number \_\_\_\_\_

2) Type: \_\_\_\_\_ Location of tumor: \_\_\_\_\_ Age at Diagnosis \_\_\_\_\_

Surgery: \_\_\_\_\_ Chemotherapy: \_\_\_\_\_ Radiation: *Yes No*

Hospital/ Doctor/ contact number \_\_\_\_\_

Have you had any significant environmental exposures: \_\_\_\_\_

Comments:

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### PREVIOUS RISK ASSESSMENT/COUNSELING

Have you ever had cancer risk assessment before? *Yes No*

If YES, Name of genetic counselor/MD \_\_\_\_\_

Institution: \_\_\_\_\_

Have you ever had genetic testing? *Yes No*

If Yes, please send us a copy of the test report

What type? \_\_\_\_\_

Result \_\_\_\_\_

Has anyone else in your family had genetic testing? *Yes No*

If Yes, please send us a copy of the test report

What type? \_\_\_\_\_

Result \_\_\_\_\_

### RESEARCH PARTICIPATION

Have you ever participated in a research study in cancer? *Yes No*

If YES, Name of study/Topic: \_\_\_\_\_

Name of Institution/Hospital: \_\_\_\_\_

Any other relatives also participated in same or different study? *Yes No*

If YES, please explain \_\_\_\_\_