



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

1st 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 1st _____ Date of Most Recent _____ Frequency _____

Breast Ultrasound: *Yes No* Age at 1st _____ 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 1st _____ 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:

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 _____