** *Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Oncology Genetics & Survivorship Center*

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_

Primary Care Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** *(please list reaction such as swelling, hives, breathing problems)*
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History (Check all that apply)**⃝ Asthma ⃝ COPD ⃝ Sleep Apnea ⃝ Congestive Heart Failure

⃝ Coronary Artery Disease ⃝ Hypertension ⃝ Hyperlipidemia ⃝ Myocardial Infarction

⃝ Arthritis ⃝ Osteoporosis ⃝ Liver Disease ⃝ Heartburn/GERD

⃝ Seizures ⃝ Stroke ⃝ TIA ⃝ Diabetes Mellitus

⃝ Kidney Disease ⃝ Thyroid Disease ⃝ DVT/PE (Clotting Disorder)

Additional Medical Issues:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal history of cancer?** If **YES,** **year diagnosed** \_\_\_\_\_\_\_\_\_\_ and please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment:** ⃝ Chemotherapy ⃝ Radiation ⃝ Surgery ⃝ Hormonal Therapy ⃝ None ⃝ Other

**Past Surgical History** *(please list all previous surgical procedures)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Social History**

**Alcohol use:** ⃝ Never ⃝ Occasionally ⃝Monthly ⃝ Weekly ⃝ Daily

**Tobacco use:** ⃝ Never ⃝ Occasionally ⃝ Current everyday use ⃝ Quit\_\_\_\_\_\_

**For Women Only**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
OB/Menstrual History**

Age at First Menstrual Cycle? \_\_\_\_\_\_\_\_\_

Present Menstrual Status? ⃝ Premenopausal ⃝ Removal of Ovaries ⃝ Menopausal

⃝ Post-Menopausal (AGE \_\_\_\_\_\_\_\_) ⃝ Uterine Ablation

Have you ever been pregnant? ⃝ Yes ⃝ No Age at first live birth? \_\_\_\_\_\_\_\_\_

**Birth Control Use: ⃝ Currently ⃝ Previously ⃝ Never Years Used?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hormone replacement use: ⃝ Currently ⃝ Previously ⃝ Never Years Used?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type: ⃝ Estrogen Only ⃝ Progesterone Only ⃝ Estrogen/Progesterone

 ⃝ Patch or topical/vaginal creams

Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_ Previous Breast Biopsy? ⃝ Yes (Date) \_\_\_\_\_\_\_\_ ⃝ No

**Family History**

Immediate family (Please list numbers of each)

Brothers \_\_\_\_\_\_\_\_\_\_ Sisters \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sons \_\_\_\_\_\_\_\_\_\_ Daughters \_\_\_\_\_\_\_\_\_\_\_

Fathers Side: Father’s Brothers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s Sisters \_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Side: Mother’s Brothers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Sisters \_\_\_\_\_\_\_\_\_\_\_

Family includes *parents, children, siblings, grandparents, aunts, uncles, and cousins*

**Family Oncology History**

|  |  |  |
| --- | --- | --- |
| **Cancer Type** | **Family Member(s)** Please indicate Maternal or Paternal  | **Age of Diagnosis** |
| Breast |  |  |
| Ovarian |  |  |
| Colon |  |  |
| Uterine |  |  |
| Melanoma |  |  |
| Pancreatic |  |  |
| Stomach |  |  |
| Prostate |  |  |
| Other |  |  |

**Are you of Ashkenazi Jewish Decent?** ⃝ Yes ⃝ No

**Any personal or family history of BRCA gene testing?** ⃝ Yes ⃝ No

If **YES**, who was tested and what was the result*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Current Medications** *(please include dose and reason for taking)*

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**Review of Systems**

**Constitutional**Appetite Change Yes No
Fatigue Yes No
Fever Yes No
Weight Change Yes No

**Ear/Nose/Throat**
Congestion Yes No
Ear Pain Yes No
Hearing Loss Yes No
Mouth Sores Yes No
Nosebleeds Yes No
Sore Throat Yes No
Ringing in Ears Yes No
Trouble Swallowing Yes No

**Respiratory**
Chest Tightness Yes No
Cough Yes No
Shortness of Breath Yes No
Wheezing Yes No

**Cardiovascular**
Chest Pain Yes No
Leg Swelling Yes No
Palpitations Yes No

**Gastroenterology**
Abdominal Pain Yes No
Blood in Stool Yes No
Constipation Yes No
Diarrhea Yes No
Nausea Yes No
Vomiting Yes No

**Endocrinology**
Cold Intolerance Yes No
Heat Intolerance Yes No

**Urology**
Difficulty Urinating Yes No
Painful Urination Yes No
Frequency Yes No
Blood in Urine Yes No
Urgency Yes No
 **Musculoskeletal**
Joint Pain Yes No
Back Pain Yes No
Difficulty Walking Yes No
Joint Swelling Yes No
Muscle Pain Yes No

**Dermatology**
Color Change Yes No
Rash Yes No
Wound Yes No

**Neurological**
Dizziness Yes No
Headaches Yes No
Numbness Yes No
Seizures Yes No
Weakness Yes No

**Hematology**
Swollen Lymph Nodes Yes No
Bruises/Bleeds Easily Yes No

**Psychiatric**
Confusion Yes No
Depression Yes No
Nervous/Anxious Yes No
Sleep Disturbance Yes No