

**HEALTH HISTORY QUESTIONNAIRE
NORTH BAY CANCER RISK ASSESSMENT SERVICES**

Appointment date and time: _____ **Visit type:** _____ **Referred by:** _____

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____ AGE: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____ Cell Phone: _____

E-mail: _____

Primary Care Provider: _____ Phone: _____

Reason for Referral: _____

INSURANCE INFORMATION

Primary: _____ PPO _____ HMO _____ Secondary: _____

YOUR PAST MEDICAL HISTORY

Has a health care provider ever told you that you have:

Asthma	Y	N	Diabetes	Y	N	High cholesterol	Y	N
Bi-polar disorder	Y	N	Heart disease	Y	N	Kidney disease	Y	N
Cancer	Y	N	Hepatitis	Y	N	Seizures	Y	N
Depression	Y	N	High blood pressure	Y	N	Thyroid problems	Y	N

Major illnesses (including dates) _____

Operations (dates and reason for surgery) _____

Hospitalizations (dates and reasons for admission) _____

What medications do you take regularly? _____

Do you have any allergies? _____

YOUR CANCER HISTORY

Have you ever been diagnosed with cancer? Yes No If **yes**, please complete the information below:

Site (ex. breast)	Type of cancer (ex. invasive ductal)	Age	Year of Diagnosis	Type of Treatment*	Hospital	City/State

*examples: lumpectomy, mastectomy, hysterectomy, salpingo-oophorectomy, colectomy, radiation, chemotherapy

YOUR REPRODUCTIVE HISTORY (women only)

Are you still having periods? Yes No If **no**, at what age did your periods stop? _____ Type of menopause: _____ Natural _____ Medication induced _____ Removal of ovaries _____ Hysterectomy _____ Radiation therapy induced

Are you taking any hormone preparations (estrogen, progesterone, birth control pills)? Yes No If **yes**, please describe and state how long _____

Have you taken hormones in the past? _____ If **yes**, type _____ how long: _____

At what age did your periods start? _____ If you have been pregnant, please complete the following: _____ # of pregnancies _____ # of living children _____ # of miscarriages/abortions _____ age of first live birth _____ # of years breastfeeding

Have you taken any infertility drugs? Yes No What drug? _____

When was your last Pap smear? _____ Any abnormal Paps? _____

Has your uterus been removed (hysterectomy)? Yes No If **yes**, reason and year: _____
 Were both ovaries removed as well? Yes No _____ One ovary removed
 Why was surgery performed? _____

Have you ever had screening for ovarian cancer? Yes No If **yes**, most recent screening _____
 Did you have: CA125(blood test) Transvaginal ultrasound Pelvic exams How frequent? _____

YOUR BREAST HISTORY

Have you had a mammogram? Yes No If **yes**, when/where was your last mammogram? _____
 Have you ever had an abnormal mammogram? If **yes**, when and what was the result and recommendation? _____

Have you ever had a breast MRI? If **yes**, when and why was it done? _____

Have you ever had a breast biopsy? Yes No If **yes**, when? _____ Which breast? _____
 What was the result? _____

If you have had other biopsies, please describe: _____

Have you had any other breast surgery? _____ Augmentation (implants)/when? _____ Breast reduction/when? _____
 Risk Reducing Surgery (Prophylactic Mastectomy)/when? _____ Unilateral _____ Bilateral _____

Do you currently have any breast problems? _____

Have you ever taken a drug to prevent breast cancer or the recurrence of breast cancer? ____ Yes ____ No

If **yes**, please complete table:

DRUG	Date Started	Reason Stopped	Date Stopped	Reason Stopped

YOUR BACKGROUND

What is your ethnicity?

____ Asian/Pacific Islander ____ African-American ____ Hispanic/Latino ____ Native American ____ White/Caucasian

Do you know where your ancestors are from (examples: England, Germany, Russia, Ireland)? ____ Yes ____ No

My mother's ancestor's are from: _____

My father's ancestor's are from: _____

Are you of Ashkenazi Jewish (Northern and Central Europe) ancestry? ____ Yes ____ No ____ Not sure

LIFESTYLE AND DIETARY HISTORY

What is your marital status? ____ single ____ married ____ partnered ____ separated ____ divorced ____ widowed

What is your highest grade of education? ____ grade school ____ high school ____ technical school
____ some college ____ college graduate ____ post graduate degree

How often do you participate in planned exercise?

____ never ____ rarely ____ less than twice a week ____ twice a week ____ 3 or more times a week

Height ____ Current weight ____ 3 months ago ____ one year ago ____ Bra size _____

Do you drink coffee regularly? ____ Yes ____ No When did you start? _____ How many cups do you drink each day? _____

Do you drink alcohol? ____ Type _____ How many drinks per week? _____ How many years at this average? _____

Describe any recreational drug use: _____

Have you ever smoked? ____ Yes ____ No What product? _____ If you currently smoke cigarettes, how many packs/day? _____

If you have quit, how many years did you smoke? _____ When did you quit? _____

If you have not smoked, have you ever lived with a smoker? ____ Yes ____ No How many years? _____

How many moles do you have? ____ fewer than 10 ____ over 10 ____ over 20 ____ over 50 ____ over 100

Have you ever had any skin lesions, skin bumps or cysts (e.g. squamous cell carcinoma, melanoma, lipoma, atypical moles) removed? ____ Yes ____ No

If **yes**, describe, give age and date: _____

How many times did you suffer a blistering sunburn before age 20? _____

Do you use a UV tanning bed regularly? ____ Yes ____ No If **yes**, how often? _____

When was your stool last checked for hidden blood? _____ Result? _____

Have you had a sigmoidoscopy or colonoscopy? _____ When? _____ Result? _____

Have you had a DEXA (bone density) scan? _____ Date _____ Normal _____ Osteopenia _____ Osteoporosis

Are you on medication? _____ Is there a family history of osteoporosis? _____ Yes _____ No

Do you perform breast self-examination (BSE)? _____ Yes _____ No _____ How often? _____ When? _____

Are you interested in BSE instruction? _____ Yes _____ No

How often do you have a breast exam performed by a health care provider? _____ Last exam: _____

Have you seen a genetic counselor, had genetic testing or had an assessment to evaluate your risk of hereditary cancer?

_____ Yes _____ No If **yes**, please explain:

Has anyone in your family had genetic testing? _____ Yes _____ No If **yes**, who has been tested?

How would you rate your risk of developing breast, ovarian or colon cancer? _____ Low _____ Medium _____ High _____ Not sure

How concerned are you about developing breast or ovarian cancer?

_____ Not at all _____ Rarely worry _____ Occasionally worry _____ Very worried _____ Worry constantly

Are you using any of the following for support? _____ Professional counselling _____ Friends/Family _____ Support group

ENVIRONMENTAL HISTORY

Please list all the places you have lived for three years or longer starting with childhood.

City	State	Country	# of years

Have you had any environmental exposure that you believe may have affected your health (examples might be chemicals, fertilizers, asbestos, glue, dry cleaning solvents, paint products, etc.)? If so, please describe:

Medical History of Your Family:

You, Your Spouse, Your Parents and Your Grandparents

Please complete with the **full name and date of birth of each family member**, age or date of death, if applicable. Include only your blood relatives and your spouse. Do not include adoptive, foster or step parents. If you do not know the exact date of birth, try to give a reasonable estimate of the year in which they were born. For each relative, please mark whether or not they have had cancer. For those with a history of cancer, please fill the organ and/or the type of cancer. For your **female relatives**, please indicate whether the person has had surgery **to remove her ovaries and at what age, if known**.

	First Name	Last Name	Birth Year	Age Now	If deceased, AGE and year of death	Cancer Yes/No	Age at Diag	In what organ did the cancer start?	If ovaries removed, what age?
Self					/				
My Mother					/				
My Father					/				
My Mother's Mom					/				
My Mother's Dad					/				
My Father's Mom					/				
My Father's Dad					/				
My 1st Spouse					/				
My 2nd Spouse					/				

Medical History of Your Family:

Your Brothers and Sisters

Please complete with the **full name and date of birth of all your siblings**, living and deceased. Please complete age or date of death where it is applicable. If you do not know the exact date of birth, try to give a reasonable estimate of the year in which they were born. For each brother or sister, please mark whether or not they have had cancer. For those with a history of cancer, please fill the organ and/or the type of cancer. For your sisters, please indicate whether the person has had surgery **to remove her ovaries and at what age, if known**.

Sister/Brother	First Name	Last Name	Birth Year	Age Now	If deceased, AGE and year of death	Cancer Yes/No	Age at Diag	In what organ did the cancer start?	If ovaries removed, what age?
					/				
					/				
					/				
					/				
					/				
					/				
					/				

Medical History of Your Family:

Your Children

Please complete with the **full name and date of birth of each child**. Please complete age or date of death where it is applicable. For each child, please mark whether or not they have had cancer. For those with a history of cancer, please fill the organ and/or the type of cancer. For your **daughters**, please indicate whether the person has had surgery **to remove her ovaries and at what age, if known**.

Daughter/Son	First Name	Last Name	Birth Year	Age Now	If deceased, AGE and year of death	Cancer Yes/No	Age at Diag	In what organ did the cancer start?	If ovaries removed, what age?
					/				
					/				
					/				
					/				
					/				
					/				
					/				
					/				

Medical History of Your Family:

Your Mother's Brothers and Sisters

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include full and half siblings. Do not include adopted siblings. If you don't know the exact date of birth, try to give a reasonable estimate of the year in which they were born. For each relative, please mark whether or not they have had cancer. For those with a history of cancer, please fill the organ and/or the type of cancer. For your **aunts**, please indicate whether the person has had surgery **to remove her ovaries and at what age, if known**.

Aunt/Uncle	First Name	Last Name	Birth Year	Age Now	If deceased, AGE and year of death	Cancer Yes/No	Age at Diag	In what organ did the cancer start?	If ovaries removed, what age?
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					/				
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Medical History of Your Family:

Your Father's Brothers and Sisters

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include full and half siblings. Do not include adopted siblings. If you don't know the exact date of birth, try to give a reasonable estimate of the year in which they were born. For each relative, please mark whether or not they have had cancer. For those with a history of cancer, please fill the organ and/or the type of cancer. For your **aunts**, please indicate whether the person has had surgery **to remove her ovaries and at what age, if known**.

Aunt/Uncle	First Name	Last Name	Birth Year	Age Now	If deceased, AGE and year of death	Cancer Yes/No	Age at Diag	In what organ did the cancer start?	If ovaries removed, what age?
					/				
					/				
					/				
					/				
					/				
					/				
					/				
					/				

Any other relatives with cancer (i.e., nieces, nephews, first or second cousins, great aunt/uncles)

Medical History of Your Family:

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. If you don't know the exact date of birth, try to give a reasonable estimate of the year in which they were born. For those with a history of cancer, please fill the organ and/or the type of cancer. For your **female relatives**, please indicate whether the person has had surgery **to remove her ovaries and at what age, if known**.

Relationship to You (Maternal or Paternal relative)	The parents of this person were	First Name	Last Name	Birth Year	Age Now	If deceased, AGE and year of death	Cancer Yes/No	Age at Diag	In what organ did the cancer start?	If ovaries removed, what age?
						/				
						/				
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						/				

Thank you