# Cancer Risk Assessment & Genetics Program

*Please Complete (Please Print)*

Today's Date: ____________________ Social Security #: ______________________________

Patient Name:________________________________ Date of Birth:_______________ Age: ______

Mailing Address: ______________________________________________________________________

City: ______________________________ State:______ Zip Code:_______________

Home Phone: ____________________________ Work/Cell Phone: __________________________

E-mail Address: _______________________________________________________________________

**Preferred Method of Contact:** □ Home phone □ Work Phone □ Cell Phone
**Is it ok to leave information regarding appointments on your preferred phone number's voicemail/answering machine:** □ Yes □ No

**Sex:** □ M □ F **Marital Status:** □ S □ M □ W □ D □ Other: _______ **Religion:** _________________

**Education:** □ Less than Grade □ 12 High School Graduate □ Some College Study
□ College Graduate □ Graduate Degree □ Other: ____________

**Race:** □ African American □ Asian □ Caucasian
□ Native American □ Hispanic □ Other:___________ □ Unknown

**Ethnicity:** __________________ **Ashkenazi Jewish ancestry:** □ Yes □ No **Language:**_______________

**Occupation/Employer (if applicable):**_____________________________________________________

**Name of Subscriber of Health Insurance if other than you:**_____________________________________

**Subscriber's DOB:**____________ **Subscriber's Social Security #:** _______________________

**Emergency Contact: Name:** ____________________________ **Phone:**_________________________

**Relationship:**_______________________________________________________

**Referring Physician:** _______________________ **Primary Care Physician:** _______________________

**Physicians to whom genetics information may be released:** (This may include a summary note and genetic test result(s), if applicable. This Information may become part of your medical record kept by your physicians):

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**Patient Signature**________________________________________ **Date:** __________________________

## Personal History

| Height: | Weight: |
|---|---|
| Previous Surgery: Types(s) | Reason(s): |

Medical Conditions (hypertension, diabetes, etc)

Medications (including alternative medications):

| Personal Cancer History: Type(s) | Age(s) at Diagnosis | Treatment |
|---|---|---|
| | | |
| | | |
| | | |

# Diet, Lifestyle & Exposure History

| | | 0 | 1-2 | 3+ |
|---|---|---|---|---|
| 2. Exercise: **(per WEEK)** | Light (stretching, casual walking, etc) | | | |
| | Moderate (fitness walking, etc) | | | |
| | Heavy (running, swimming, etc) | | | |

| | | 81 mg | 325 mg |
|---|---|---|---|
| 3. Aspirin Use: | Daily | | |
| | Occasional | | |
| | Never | | |

| | | None | #/day | Duration |
|---|---|---|---|---|
| 4. Smoking/ Tobacco Use: | Cigarettes | | | |
| | Cigars/Pipes | | | |
| | Chew Tobacco | | | |

| | 0 | 1-2 | 3+ |
|---|---|---|---|
| 5. Alcohol: **(drinks per DAY)** | | | |

| | | | | |
|---|---|---|---|---|
| 6. Daily Supplements: | | Vitamin E | | Multi-vitamin |
| | | Selenium | | Other: |

| 7. Diet **(servings per DAY)**: | 0 | 1-2 | 3-4 | 5 + |
|---|---|---|---|---|
| Animal-fat products (meat, eggs, cheese, milk, etc) | | | | |
| Tomato-based products (salsa, tomato sauce, etc) | | | | |
| Fruits and Vegetables (non-tomato) | | | | |
| Vegetable-based oils/fats (canola, olive, etc) | | | | |
| Whole grains (bread, cereal, etc) | | | | |

8. Sun Exposure History? (circle) Mild Moderate Significant

Routine Dermatologic Exams? YES NO

History of Dysplastic Nevi? YES NO

Other skin findings? (lipoma, etc.) YES NO

If yes, please list: ____________________________________________________

9. Previous Colonoscopy? YES NO

If yes, age at most recent colonoscopy:____________

If yes, do you have a history of polyps? YES NO

If yes, please record polyp number and type: ___________________________________

## Females Only

Current Age: _________

Most Recent Self Breast Exam: Never Month________ Year______

Most Recent Clinical Breast Exam: Never Month________ Year______

Most Recent Mammogram: Never Month________ Year______

Most Recent Breast MRI: Never Month________ Year______

Age at First Period: _________ Age at First Birth:________

Age at Menopause: __________

Number of Breast Biopsies: ______________

History of Atypical Ductal Hyperplasia or Lobular Neoplasia? YES NO

History of Hormonal Contraceptive Use (Birth control pill, patch, etc)? YES NO

If yes, age(s) and duration of use: _____________________________________________

History of Fertility Medications? YES NO

If yes, list names, age(s) and duration of use: _____________________________________________

History of Hormone Replacement Therapy Use? YES NO

If yes, list names, age(s) and duration: _____________________________________________

History of Tamoxifen/Evista Use? YES NO

If yes, which medication and duration: _____________________________________________

Annual Gynecologic Exams? YES NO

Ovarian Cancer Screening? YES NO UNKNOWN

If yes, type: CA-125 Transvaginal Ultrasound

Please list primary concern(s) for this appointment:

_________________________________________________________________________

## Males Only

Current age: __________

Prostate Cancer Screening? YES NO

If yes, have you ever had an elevated PSA? YES NO

Do you have a history of benign prostatic hyperplasia (BPH)? YES NO

Annual Physical Examination? YES NO

Please list primary concern(s) for this appointment:

________________________________________________________________________________