

WOMEN'S HEALTH QUESTIONNAIRE UPDATE

Since your last visit to our office, your life may have changed and this may affect your health. Please help us to provide the best health care for you by completing this short questionnaire.

NAME _____

DATE _____

What brings you to our office today? _____

	<i>Circle One</i>	<i>Circle One</i>	<i>If yes, please specify...</i>
Have you changed your occupation.....	Yes	No	_____
Do you have any problems at home that you notice affect your health or stress level?.....	Yes	No	_____
Has there been any significant change in your relationship with your husband, partner, or boyfriend?.....	Yes	No	_____
Has there been a change in your menstrual period?	Yes	No	_____
Date of your last period _____			
Do you use a method of contraception?.....	Yes	No	Do you use it regularly? Are you/your partner satisfied with this method? _____
If yes, what type? Pills IUD Diaphragm Condoms Natural/Rhythm Spermicide Other _____			
Do you want any information about birth control?.....	Yes	No	_____
Date of your last Pap test? _____			
Do you have any questions about safer sex?.....	Yes	No	_____
Do you smoke cigarettes?.....	Yes	No	How many per day? _____
Do you use street drugs?.....	Yes	No	_____
Do you drink alcohol?.....	Yes	No	How often? How Much? _____
Have you ever felt the need to cut down your drinking?	Yes	No	_____
Are you exercising?.....	Yes	No	How often? What type? _____
Have you had any illnesses?.....	Yes	No	_____
Have you seen any of your other doctors recently?.....	Yes	No	_____
Are you taking any medicines now?.....	Yes	No	_____

Please answer if you are over 39:

Approximate date of your last mammogram _____

Approximate date of your last stool test _____

Approximate date of your last cholesterol or complete lipid panel test _____

Would you like more information on new testing available for early cancer detection and/or osteoporosis? Yes No

Do you have any other questions, problems or concerns that you would like to discuss with us today? _____

Personal/Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
 Date of Birth: _____ Date: _____

Instructions: Please circle **Y** to those that apply to **YOU and/or YOUR FAMILY** (on both your **mother's or father's side**). Next to each statement, please list the **relationship to you** of the individual diagnosed (such as self, paternal aunt, maternal uncle, paternal grandmother) and their **age of diagnosis**. Answer each statement individually – you may list the same cancer diagnosis more than once as you answer each question. This is a screening tool for the common features of hereditary cancer syndromes. If you circle **Y** to any of the statements below, you **MAY** be appropriate for genetic testing. Ask your healthcare provider for additional information.

BREAST AND OVARIAN CANCER:

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50		
Y	N	Ovarian cancer		
Y	N	Breast cancer in both breasts or multiple primary breast cancers		
Y	N	Both breast and ovarian cancer in an individual OR a family		
Y	N	Male breast cancer		
Y	N	2 or more breast or ovarian cancers in an individual OR family		
Y	N	Ashkenazi Jewish ancestry and a personal or family history of breast or ovarian cancer		

COLON AND UTERINE CANCER:

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50		
Y	N	Colon cancer before age 50		
Y	N	Both uterine and colon cancer in an individual OR a family		
Y	N	2 or more uterine or colon cancers in an individual OR family		
Y	N	Uterine AND/OR colon cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in an individual or family		
Y	N	10 or more colon polyps found in a lifetime		

MELANOMA:

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	2 or more melanomas in an individual or family		
Y	N	Both melanoma and pancreatic cancer in an individual or family		

FOR THE HEALTHCARE PROVIDER:

<input type="checkbox"/> Candidate for further risk assessment and/or genetic testing <input type="checkbox"/> Information given to patient to review <input type="checkbox"/> Follow up appointment scheduled: _____ <input type="checkbox"/> Patient offered genetic testing: <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED
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Patient's Signature: _____ Date: _____
 Health Care Provider's Signature: _____ Date: _____