HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	----	--	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME GASTROINTESTINAL POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more gastrointestinal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

Hereditary Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: _____

HIPPA CONSENT

CONSENT TO LEAVE A MESSAGE

Patient Name: _____ Date:_____

I wish to be called at home ☐; other ☐(check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

_____home _____other

I do ☐, I do not ☐give permission to leave relevant medical information on my answering machine or voice mail.

I do ☐, I do not ☐want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

_____

_____

_____ _____

Patient Signature Date

Center for Women's Health

Patient Medical History Form

Name: _____ Date of Birth _____ Today's Date: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Medical History

Have you ever had any of the following?

☐ Anemia	Past or Current	☐ Hair growth (abnormal/excessive)	Past or Current
☐ Arthritis	Past or Current	☐ Hair loss	Past or Current
☐ Asthma	Past or Current	☐ Heart Disease/Attack	Past or Current
☐ Bladder Infections	Past or Current	☐ High Blood Pressure	Past or Current
☐ Bleeding Problems	Past or Current	☐ Kidney Infections	Past or Current
☐ Blood Clots in lungs/legs	Past or Current	☐ Liver Disease/Hepatitis	Past or Current
☐ Blood Transfusion	Past or Current	☐ Migraines	Past or Current
☐ Cancer:	Past or Current	☐ Mitral Valve Prolapse	Past or Current
		☐ Ovarian Cysts	Past or Current
☐ Chicken pox	Past or Current	☐ Pelvic Infections	Past or Current
☐ Diabetes	Past or Current	☐ Pneumonia	Past or Current
☐ Depression/Anxiety	Past or Current	☐ Sickle Cell Disease	Past or Current
☐ Drug/Alcohol Problems	Past or Current	☐ Stroke	Past or Current
☐ Endometriosis	Past or Current	☐ Thyroid Problem	Past or Current
☐ Epilepsy/Seizures	Past or Current	☐ Tuberculosis	Past or Current
☐ Fibrocystic Breasts	Past or Current	☐ Urinary Problems	Past or Current
☐ Gall Bladder Disease	Past or Current	☐ Uterine Fibroids	Past or Current
☐ Gardasil Vaccine	Past or Current	☐Weight loss (abnormal)	Past or Current
☐ Genetic Condition:		☐ Weight gain(abnormal)	Past or Current
		☐ Other:	

Social History

Alcohol Use	☐ Yes	☐ No	☐ Past	If yes, _____ drink(s) per day/week/month
Tobacco Use	☐ Yes	☐ No	☐ Past	If yes, _____ pack(s) per day for _____ years
Street Drug Use	☐ Yes	☐ No	☐ Past	Type and frequency _____
Exercise	☐ Yes	☐ No	☐ Past	Type and frequency _____
Sexual Abuse	☐ Yes	☐ No	☐ Past	If yes, are you safe now? ☐ Yes ☐ no Counseling? ☐ yes ☐ no
Physical Abuse	☐ Yes	☐ No	☐ Past	If yes, are you safe now? ☐ Yes ☐ no Counseling? ☐ yes ☐ no
Emotional Abuse	☐ Yes	☐ No	☐ Past	If yes, are you safe now? ☐ Yes ☐ no Counseling? ☐ yes ☐ no

Employed: Full Part Location:

Highest Level of Education: High School/ College or University/Post Graduate/Other: _____

Diet: Regular/ Vegetarian / Diabetic/ Other: _____

Drug Allergies

List any allergies to medications:

☐ No Known Drug Allergy

Drug	Reaction

Current Medications/Vitamins

List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies: (continue on back if necessary)

☐ No Home Medications or Vitamins

Medication	Dose	Frequency

Pregnancy Summary – (Continue on back if necessary) ☐ Have never been pregnant

*Please include miscarriages, terminations, and ectopic pregnancies

Child's Birth Date	# weeks at Delivery	Length of Labor	Birth Wt.	Male or Female	Type of Delivery (Vaginal or C/S)	Anesthesia	Complications or Problems	Location

Center for Women's Health

Procedures and Surgery History

Please list all procedures and surgeries that you've had:

Procedure/Surgery	Date

Family Medical History:

Has anyone in your family ever had any of the following conditions?
If so, please circle and write details in the right column:

Parent History:
Mother: Living or Deceased – DOB: _____ (Age at death ____)
Father: Living or Deceased – DOB: _____ (Age at death ____)
Siblings: Brother(s) ____ Sister(s) ____

Condition:	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other:
Birth Defects							
Bleeding Problems							
Blood Clots							
Breast Cancer							
Colon Cancer							
Diabetes							
Genetic Diseases							
Heart Disease							
High Blood Pressure							
Lung Cancer							
Multiple Births (Twins, Triplets)							
Ovarian Cancer							
Osteoporosis							
Prostate Cancer							
Uterine Cancer							
Any Other Cancer							
Other:							

Center for Women's Health

Gynecological History

Menstrual History:
Age of 1st period: ____
How often does period occur: every _____ days
How long does it last: _____ days

Age of menopause: ____

Periods are:
☐ Regular
☐ Irregular
☐ Painful
☐ Not really bothersome

Flow is:
☐ Light
☐ Light to Moderate
☐ Moderate to heavy
☐ Very Heavy

Are you sexually active?
☐ Yes
☐ No
☐ Virgin

Sexual preference:
☐ Heterosexual
☐ Homosexual
☐ Bisexual

New partners?
☐ Yes
☐ No

Number of current partners: _____
Number of lifetime partners: _____

Current Method of Birth Control:
☐ Condoms ☐ Vaginal Ring ☐ Partner with vasectomy ☐ Other
☐ Pills ☐ Tubal/Essure ☐ Natural family planning ☐ None
☐ Patch ☐ IUD ☐ Implanon/Nexplanon

Have you ever had any of the following STDs?
☐ Chlamydia ☐ HPV ☐ HIV ☐ Venereal Warts
☐ Gonorrhea ☐ Syphilis ☐ Hepatitis B
☐ Herpes ☐ Trichomonas ☐ Hepatitis C ☐ None

Date of last pap smear: _____ ☐ Normal ☐ Abnormal
Treatment for Abnormal Pap: ☐ Colposcopy ☐ LEEP/Laser/Conization
☐ Cryosurgery ☐ None

Date of last Mammogram: _____ ☐ Normal ☐ Abnormal ☐ None

Date of last Bone Density: _____ ☐ Normal ☐ Osteopenia
☐None ☐ Osteoporosis

Date of last Colonoscopy: _____ ☐ None

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR NON-MEDICARE PATIENTS

I hereby authorize and direct my insurance benefits to be paid to my personal physician or his/her group practice, Center For Women's Health of Lansdale.

I also authorize my physician or group practice to release any information necessary to process this claim. I understand that information will be released to:

- billing department of the physician and/or practice
- insurance carrier to process claim

I understand that my information, under certain circumstances may be released for one of the following reasons:

- other health care professionals in order to coordinate my care or treatment
- insurance adjustor-if my claim is a work or motor vehicle injury
- employer-if my claim is related to a work injury
- attorney-if my claim is in a litigation process
- health insurance company, for chart audit reasons, not for claim payment

I understand that my physician and/or his staff and the billing office will not release any information to myself or family members over the phone without verification of my identity in order to comply with privacy regulations. I also understand that my physician and his/her staff and the billing office will maintain the utmost respect for privacy. However, I also understand that there are physical constraints such as noise and the ability for others to overhear information, and other errors that may occur that may cause inadvertent disseminaton of information, as well as the potential for confidential information to be disclosed after it has been provided to outside sources such as your insurance carrier from the clinical or billing office.

This office is not responsible for any disclosure of your confidential medical information once we provide this information, AT YOUR request , to your insurer, employer, family member or otherwise.

With this full understanding, I indemnify and hold harmless this practice for any disclosure, which is out of my physicians, his staff and/or his billing office control.

By my signature, I state that I have read, understand, and agree to this Authorization and Release.

_____ _____

Patient or Guardian Signature Date

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as CENTER FOR WOMEN'S HEALTH OF LANSDALE or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing.

This practice, however may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____

Name of Patient *(Print Clearly)*

_____

Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, authorize this medical practice to disclose the information listed, to the individuals listed below.

I understand that information disclosed to this (these) individual may re-disclose information inadvertently to other parties. The privacy of this information may not be protected under the federal privacy regulations. This practice does not take responsibility for any disclosure made by the individual(s) listed below.

You may revoke or terminate this authorization by submitting your request in writing. Please contact the Privacy Officer if you should wish to terminate or change this authorization at a later date.

I authorize the disclosure of the following information:

_____

_____

_____

_____

Information described above may be disclosed to:

_____

Name of Person and Relationship to patient or Name of Organization

_____

Name of Person and Relationship to patient or Name of Organization

_____

Name of Person and Relationship to patient or Name of Organization

_____ _____

Patient Signature Date

PATIENT INFORMATION
PLEASE COMPLETE EACH LINE
PRINT CLEARLY

LAST NAME _____ FIRST _____ MIDDLE INITIAL _____

STREET ADDRESS _____ APPARTMENT NO. _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ EMERGENCY NO. _____

D.O.B._____ SS# _____

WHO REFERED YOU? _____(INDICATE FULL NAME OF PHYSICIAN)

INSURANCE INFORMATION Is this a work related or MVA injury? _____ Accident date_____

If so, claim no. _____ Adjuster_____

NAME OF INSURANCE_____

MAILING ADDRESS (Usually on back of card)_____

PHONE NO._____

GROUP NO. _____ IDENTIFICATION OR POLICY NO._____

SUBSCRIBER'S NAME_____SUBSCRIBER'S EMPLOYER_____

SUBSCRIBER'S BIRTHDATE_____ SUBSCRIBER'S SS# _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT_____

SUBSCRIBER'S ADDRESS (If different from patient) _____

_____ SUBSCRIBER'S PHONE # (If different from patient)_____

SECOND INSURANCE INFORMATION

NAME OF INSURANCE_____

MAILING ADDRESS (Usually on back of card)_____

PHONE # _____

GROUP#_____IDENTIFICATION OR POLICY # _____

IF PATIENT IS A CHILD AND IS COVERED UNDER BOTH PARENTS – WHO'S BIRTHDAY (MOTHER OR FATHER) IS CLOSEST TO JANUARY 1? _____

SIGNATURE_____ DATE _____