Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

Date: _____

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE - FEMALE

Welcome to the Cancer Genetics Risk Assessment and Counseling Program at the UW Health. You have been referred because of your personal and/or family history of cancer.

We need information about your personal and family medical history to help us prepare for your visit. We understand if you do not know the answers to all of these questions, but the more information you are able to provide, the better we will be able to assess your situation.

Please complete this form and return it to:

UW Health Cancer Genetics Clinic
600 Highland Ave., K4/212
Madison, WI 53792
Attn: Department Assistant

An addressed postage paid envelope is enclosed. Alternatively, you can fax the form to 608-662-4448. If you have any questions, please call our office at 608-263-7284. **After we receive your form, we will contact you to set up an appointment with one of our genetic counselors.**

Please bring any medical records to your appointment that you think might be useful, **especially genetic test reports**. These could be your own medical records or records of your relatives.

Your Health Care Team	Primary Care Provider:	
	Referring Provider:	
	Oncologist (if appropriate):	

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)
ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE - FEMALE

PERSONAL HEALTH HISTORY

Have you ever been diagnosed with cancer? □ Yes □ No

Type of Cancer (e.g. breast, uterus, stomach, Hodgkins, etc.)	Age Diagnosed	Type(s) of treatment you received (e.g. surgery, radiation, chemo)

Personal Cancer Screening History

1) Have you ever had a mammogram? □ Yes □ No
If YES, when was your last mammogram? Month _____ Year _____
How old were you when you had your first one? _____

2) Have you ever had a breast MRI? □ Yes □ No
If YES, when was your last breast MRI? Month _____ Year _____

3) Do you have an ONGOING area of concern on a mammogram or breast MRI? □ Yes □ No
If YES, please explain _____

4) Have you ever had a breast biopsy for any reason? □ Yes □ No (If YES, please fill out table below)

Type of Surgery Needle biopsy Excisional biopsy Breast reduction Implants	**Date (Month/Year)**	**Side** Left Right Both	**Result of biopsy** Normal Atypical ductal hyperplasia (ADH) Lobular carcinoma in situ (LCIS) Other (please describe) _____

3) Have you ever had a colonoscopy? □ Yes □ No
If YES, how many colonoscopies have you had? _____
How old were you when you had your first one? _____
Have polyps been found? □ Yes □ No If YES, how many? _____

Reproductive History

1) How old were you when you had your first period? _____

2) Have you had a period within the last year? □ Yes □ No Date of last period? _____

3) Have you experience menopause yet? □ Yes □ No

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

If so, at what age did your periods end? _____

4) Has your uterus been removed? □ Yes □ No Your age when removed: _____

If YES, why was this surgery performed? _____

5) Has one or both of your ovaries been removed? □ Yes □ No If YES, your age when removed: _____

Did you have both removed? □ Yes □ No

If YES, why was this surgery performed? _____

6) Have you ever been pregnant? □ Yes □ No (If YES, please fill out table below)

How many times have you been pregnant?	
How old were you the FIRST time you delivered/had a baby?	
How many babies have you had?	

7) Are you interested in future pregnancy? □ Yes □ No □ Maybe

8) Please indicate if you have ever used any of the following medications:

Medication	Age When Started	Age When Stopped	Details
Birth control pill, oral contraceptive, or NuvaRing			
Hormone replacement therapy (HRT) Examples: Premarin, Prempro			Name of Medication:
Vaginal estrogen cream Examples: Vagifem, Estring, Estrace			
Tamoxifen			Reason used:
Raloxifene (Evista)			Reason used:
Aromatase Inhibitor (such as anastrozole, exemestane, or letrozole)			Reason used:

Past Medical History:

1) What is your current weight? _____lbs. How tall are you? _____ ft. _____ in.

2) Have you ever been told that you had a blood clot? (e.g. Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE), strone or heart attack)? □ Yes □ No If YES, what was the diagnosis and date? _____

3) Have you ever been told you have low bone density (e.g. osteopenia or osteoporosis)?
□ Yes □ No If YES, are you on any medications? _____

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

4) Have you ever been told that you have any of the following health problems?

Depression □ Yes □ No If yes, please explain _____
Liver problems □ Yes □ No If yes, please explain _____
Kidney problems □ Yes □ No If yes, please explain _____
Heart problems □ Yes □ No If yes, please explain _____
High Blood Sugar (Diabetes) □ Yes □ No
High Blood Pressure (Hypertension) □ Yes □ No

5) In the space below, please describe any other health problems or illnesses that you have been treated for:

_____

_____

_____

_____

_____

Social History:

1) What is your occupation? _____

2) Do you or have you ever smoked cigarettes? □ Yes □ No

If YES, how old were you when you started? _____

If YES, on average, how many cigarettes did/do you smoke each day? (Please circle)

None 1-2 < ½ pack 1-2 pack(s) > 2 packs

If you no longer smoke, please indicate how old you were when you quit _____

3) On average, how many servings of alcohol (wine, beer, liquor) do you drink each week?

None 1-2 3-7 4-7 7-14 > 14

4) On average, how many days per week do you currently get at least 30 minutes of exercise?
(Include only activity equal to or greater than a brisk walk)

None 1-2 3-4 5-7

Genetic Testing:

1) To your knowledge, has anyone in your family met with a genetic counselor to discuss the family history of cancer?
□ Yes □ No

2) To your knowledge, has anyone in your family had **genetic testing** for any cancer risk genes (i.e. *BRCA1, BRCA2, PALB2,* etc.)? □ Yes □ No

If YES, who was this person/how are they related to you? _____

If YES, was the testing positive for: □ BRCA1 □ BRCA2 □ Other, please explain: _____

If YES, when was testing done? _____

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

If YES, where was testing done? _____

If someone in your family has tested positive for a cancer gene mutation, please include a copy of your family member's test report if at all possible. This is essential if test results were positive.

What questions do you hope we may be able to address during your appointment?

_____

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY

Please include all members of your family, not just those that have had cancer.
If you need more room, please continue on the back page of this packet.

PART 1: YOUR CHILDREN

Child's First Name	**Gender (M or F)**	**Age**	✓ if deceased	**Type of Cancer** (leave blank if person has no history of cancer)	**Age at Cancer Diagnosis** (if applicable)

Do any of the children above have a different father or mother? If YES, please clarify:

_____

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE - FEMALE

PART 2: YOUR BROTHERS AND SISTERS

First Name	**Gender (M or F)**	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**	**His/Her Children** (your nieces/nephews)	
						Name	**Cancer Type and Age of Diagnosis**

Do any of your brothers or sisters have a different father or mother? If YES, please clarify:

_____

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE - FEMALE

PART 3: YOUR PARENTS AND GRANDPARENTS				
Your Mother's First Name	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**
Maternal Grandmother's First Name (your mother's mother)	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**
Ethnic Background of your maternal grandmother (English, Irish, German, etc.):				
Maternal Grandfather's First Name (your mother's father)	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**
Ethnic Background of your maternal grandfather (English, Irish, German, etc.):				
Your Father's First Name	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**
Paternal Grandmother's First Name (your father's mother)	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**
Ethnic Background of your paternal grandmother (English, Irish, German, etc.):				
Paternal Grandfather's First Name (your father's father)	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**
Ethnic Background of your paternal grandfather (English, Irish, German, etc.):				

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE - FEMALE

PART 4: YOUR MATERNAL AUNTS, UNCLES AND COUSINS							
First Name of mother's sisters and brothers	**Gender (M or F)**	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**	**His/Her Children** (your cousins)	
						Name	**Cancer Type and Age of Diagnosis**

Do any of the above aunts and uncles have a different father or mother? If YES, please clarify:

____

Patient Name

DOB:

MR #

Index to Questionnaire-Health\Encounter

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE - FEMALE

PART 5: YOUR PATERNAL AUNTS, UNCLES AND COUSINS

First Name of father's sisters and brothers	**Gender (M or F)**	**Age** or age at death	✓ if deceased	**Type of Cancer** (if any)	**Age at Cancer Diagnosis**	**His/Her Children** (your cousins)	
						Name	**Cancer Type and Age of Diagnosis**

Do any of the above aunts and uncles have a different father or mother? If YES, please clarify:

_____

PLEASE LIST ANY OTHER MATERNAL OR PATERNAL FAMILY MEMBERS WITH CANCER:

_____

_____

Signature of Patient/Representative: _____ Date: _____ Time: _____ AM/PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: □ Minor □ Incompetent/Incapacitated
Legal Authority: □ Legal Guardian □ Parent of Minor
□ Health Care Agent □ Other _____

Reviewed by: _____ Date: _____ Time: _____ AM/PM