Date: ______________

PERSONAL AND FAMILY HEALTH HISTORY

The purpose of this questionnaire is to identify any special needs you may have. Yours answers will remain confidential.

NAME ______________________ AGE ________ DATE OF BIRTH ______________________

ADDRESS ______________________________________

MARITAL STATUS M____ S____ D____ W____

SOCIAL SECURITY # ____________________

GRADE COMPLETED__________

HOME PHONE: ____________________

EMPLOYER ______________________

CELL PHONE: ____________________

EMERGENCY CONTACT NAME____________________

EMPLOYER PHONE____________________

EMERGENCY CONTACT PHONE____________________

LAST MENSTRUAL PERIOD____________________

PLEASE INDICATE BELOW IF YOU OR ANY OF YOUR CLOSE BLOOD RELATIVES HAVE EXPERIENCED ANY OF THE FOLLOWING:

	YOU	FAMILY
High Blood Pressure	________	________
Heart Trouble / Heart Attack	________	________
Diabetes	________	________
Brain Tumor	________	________
Seizures	________	________
Migraine Headaches	________	________
Scoliosis	________	________
Thyroid Problems	________	________
Adrenal Gland Problems	________	________
Pituitary Problems	________	________
Cushing's Disease	________	________
Bleeding Problems	________	________
Chronic Anemia	________	________
Sickle Cell Trait / Disease	________	________

PLEASE INDICATE BELOW IF YOU HAVE EVER EXPERIENCED OR BEEN TOLD THAT YOU HAVE ANY OF THE FOLLOWING:

	YOU
Rheumatic Fever	________
Scarlet Fever	________
Asthma	________
Bronchitis	________
Pneumonia	________
Hiatal Hernia	________
Ulcers	________
Gallbladder Problems / Stones	________
Crohn's Disease	________

	YOU	
Irritable Bowel Syndrome	______	
Colitis	______	
Heart Murmur	______	
Phlebitis	______	
Varicose Veins	______	
Blood Clots in Legs or Lungs	______	
Hepatitis	______	
Jaundice	______	
Kidney Stones	______	
Kidney or Bladder Infection	______	
Lymphoma	______	
Other Cancer (Specify)		
______________________	______	
Mononucleosis	______	
Encephalitis	______	
Measles	______	
Chicken Pox	______	
Gonorrhea	______	
Chlamydia	______	
Trichomoniasis	______	
Yeast Infections	______	
		Husband
Herpes	______	______
Genital Warts	______	

USUAL MENSTRUAL CYCLE: *LENGTH* ______________________
DURATION ________________ *AMOUNT* ______________________

ANY IRREGULAR BLEEDING ______________________

DID YOU HAVE ANY PROBLEMS BECOMING PREGNANT________________

HAVE YOU EVER HAD AN OPERATION ______________________
YEAR _________ *PROCEDURE* ______________________
HOSPITAL ______________________ *PHYSICIAN* ______________

HAVE YOU EVER BEEN HOSPITALIZED________________
YEAR _________ *DIAGNOSIS* ______________________

HAVE YOU EVER HAD ANY SERIOUS ACCIDENTS______________________

ARE YOU ALLERGIC TO ANY MEDICINES (SPECIFY) ______________________

PATIENT NAME ______________________ SCREENING QUESTIONNAIRE DATE______________________

		YES	NO
1.	**Will you be age 35 or older when you have children?**	____	____
2.	**Have you or your partner or anyone in either of your families ever had:**	____	____
	Down's Syndrome	____	____
	Spina Bifida or Meningomyelocele (open spine)	____	____
	Hemophilia	____	____
	Muscular Dystrophy	____	____
	Cystic Fibrosis	____	____
3.	**Have you or your partner had a child born dead or alive with a birth defect not listed in question 2 above** *If yes, describe* ______________________	____	____
4.	**Do you or your partner have any close relatives who are mentally retarded or have birth defects?** *If yes, list cause if known* ______________________	____	____
5.	**Do you or your partner or a close relative in either of your families have any inherited genetic or chromosomal disease or disorder not listed above** *If yes, describe* ______________________	____	____
6.	**Have you or your partner had 3 or more spontaneous pregnancy losses (miscarriages, stillbirths, etc.?)**	____	____
7.	**Do you or your partner have any close relatives descended from Jewish people who lived in Eastern Europe (Ashkenazi Jews)?**	____	____
	If yes, have either you or your partner been screened for Tay-Sacha disease?	____	____
	If yes, indicate results and who was screened ______________________		
8.	**Are you or your partner African American?**	____	____
	If yes, have either you or your partner, or any close relative ever been screened for sickle cell trait and found to be positive?	____	____
	If yes, indicate results and who was screened ______________________		
9.	**Do you or your partner have any close relatives descended from Mediterranean countries?**	____	____
	If yes, have you, or your partner, been screened for thalassemia (Cooley's anemia)?	____	____
	If yes, indicate results and who was screened: ______________________		
10.	**Do you drink alcoholic beverages?** *If yes, describe how often and amount:* ______________________	____	____
11.	**Do you take any medications either by prescription or those which can be purchased over the counter in a drug store** *If yes, please list drugs and dosage schedule:* ______________________	____	____
12.	**Have you ever been tested to determine if you are immune to rubella (German Measles)?** *If yes, please indicate where and when tested and results of test:* ______________________	____	____

HAVE YOU EVER DONATED BLOOD________________________

HAVE YOU EVER BEEN TESTED FOR HIV / AIDS_____________

DO YOU SMOKE____ HOW MUCH BEFORE PREGNANCY__________________
SINCE PREGNANCY ____________________________

DO YOU DRINK BEER, WINE, OR HARD LIQUOR_____________________________

DO YOU USE MARIJUANA_________COCAINE_________OTHER DRUGS_________

WHAT PRESCRIPTION OR OVER-THE-COUNTER MEDICATIONS DO YOU TAKE REGULARLY

____

DO YOU OWN A CAT__________________ DO YOU HANDLE THE KITTY LITTER_____________

PREGNANCY HISTORY

NO	YEAR	SEX	WEIGHT	HOURS IN LABOR	PROBLEMS WITH PREGNANCY OR BIRTH (Indicate miscarriages or abortions here)
1					
2					
3					
4					
5					
6					
7					
8					

For Patients with Commercial Insurance, Medicaid, or Medicare with a secondary plan

Personal & Family Cancer History

Name: ______________________ Date: __________ Date of Birth: __________ Age: _____

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides**. Specify which relatives were affected and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**
2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

		CANCER HISTORY	You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	**Yes**	BREAST CANCER diagnosed age 49 or younger					
No	**Yes**	OVARIAN CANCER at any age					
No	**Yes**	Ashkenazi Jewish heritage with a BREAST CANCER at any age					
No	**Yes**	3 or more BREAST, PROSTATE, and/or PANCREATIC CANCERS on one family side, any ages					
No	**Yes**	MALE BREAST CANCER at any age					
No	**Yes**	2 or more COLON CANCERS on a family side, at least one under 50					
No	**Yes**	3 or more COLON and/or UTERINE CANCERS on a family side, any ages					

Patient Signature ______________________________

OFFICE USE ONLY Patient offered genetic testing: Yes / No Accepted / Declined Provider Initials: __________