

Patient Name: _____ D.O.B. _____ Today's Date: _____

Personal Medical History - Female

Directions: Please answer the following questions to the best of your knowledge. Please call us at 1-800-251-0097 if you need help filling out this form, we would be happy to answer any questions.

1. What is your date of birth? _____. What is your current age? _____.
2. Have you ever had cancer? yes no. IF yes, list the type of cancer(s) you have had, the age when it was first diagnosed, and the treatment for that cancer. IF no, go to question 3.

Type of cancer (specific name if known)	Age at diagnosis	Treatment

3. If you have not had breast cancer,
 - a. Have you ever had a breast biopsy? yes no. If yes, how many? _____.
If yes, what was the result of each biopsy? _____.
4. What kinds of cancer screening (if any) do you do and how often? Any unusual results (besides any cancers listed above)? _____.
5. How old were you when you got your first menstrual period? _____.
6. Are you still having periods? yes no.
If no, approximately when was your last period? _____.
7. If you have biological children, how old were you when you had your first? _____.
8. Have you ever used birth control pills (oral contraceptives, "the pill")? yes no
If yes, for how long? _____. When? _____.
9. Have you ever used hormone replacement therapy? yes no
If yes, for how long? _____. When? _____. What kind? _____.
10. Have you ever had any polyps in your colon? yes no never had screening
If yes, how many? _____. What age(s) were they found? _____.
11. Has anyone else in your family ever had polyps in their colon? yes no
If yes, who had polyps, how many did they have, and at what age were they found? _____
_____.
12. Has anyone in your family had a benign breast tumor? yes no
13. Have any children in your family been diagnosed with ataxia-telangiectasia? yes no.
14. Does anyone in your family have "Cowden's disease" or hamartomas (that you know of)? yes no

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15. Have you or anyone in your family been told by a skin doctor, eye doctor, or other health-care professional that they have unusual findings? yes no.

If yes, please explain. _____.

16. Has anyone in your family ever had genetic testing for cancer-susceptibility genes (that you know of)? yes no. If yes, what gene or genes? _____.

17. Sometimes people don't have cancer but have a "pre-cancerous" condition or syndrome that could lead to cancer. Have you or anyone in your family ever been told you have a condition like that? Please indicate who and what they had (i.e. dysplastic nevi (abnormal moles), suspicious biopsy, neurofibromatosis, Gardner's syndrome). _____

18. Sometimes people have surgeries to remove organs that could get cancer. If you or any of your immediate relatives have had such surgeries before cancer (prophylactic surgery), please list below (i.e. hysterectomy (uterus), oophorectomy (ovaries), mastectomy (breasts), colectomy (colon), thyroidectomy (thyroid)):

First name/initials	Relationship to you	Type of surgery	Age at surgery

19. Are any of your relatives of Jewish ancestry? yes no

20. Are any of your relatives of French-Canadian ancestry? yes no

21. Are any of your relatives of Norwegian ancestry? yes no

22. Are any of your relatives of Icelandic ancestry? yes no

23. Are any of your relatives of Finnish ancestry? yes no

24. What country or countries are your ancestors from (ethnic/racial background)?

Mother's mother's family _____.

Mother's father's family _____.

Father's mother's family _____.

Father's father's family _____.

25. Is there anything else about your personal history or your family history that you would like us to know? Please use the back of this page to explain any of the above answers or for any comments.