Patient Name: _____ **Personal History Form- Female**

Appointment Date: _____ Location: _____

Directions: Please answer the following questions to the best of your knowledge. Please feel free to call us if you have any questions at 603-653-3541. Please complete and mail back to us in the envelope provided with our mailing address (DH-NCCC Familial Cancer Program One Medical Center Drive Lebanon, NH 03756 If you plan to mail your form, please mail it at least 2 weeks prior to your appointment. You may also drop off completed forms at our Manchester office.

Background Information:

1. Name:

2. DOB:

3. Have you ever had genetic testing for cancer in the past? Yes No

   If yes, please explain: _____

   Results: _____

4. Has anyone in your family had cancer genetic testing? Yes No

   If yes, how is this person related to you: _____

   Results: _____

PLEASE OBTAIN A COPY OF YOUR FAMILY MEMBER'S GENETIC TESTING RESULT. THIS RESULT IS REQUIRED FOR YOUR APPOINTMENT

5. Have you or a family member ever been diagnosed with a genetic condition? Yes No

   If yes, please explain: _____

6. What is your ancestry or ethnic background (what country/countries do your ancestors come from)?

Mother's mother's family: _____

Mother's father's family: _____

Father's mother's family: _____

Father's father's family: _____

7. Are any of your relatives of Ashkenazi Jewish Ancestry? Yes No Unsure

Personal Cancer History:

8. Have you ever had cancer? Yes No

   If yes, please list the type of cancer, age of diagnosis and treatment in the table below:

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

Personal Medical History:

9. Please fill out table with current or past cancer screening you have had

Type of screening	Yes or No	How often	Any unusual findings
Mammogram			
Gynecologic exam			
Colonoscopy			
Skin exam			
Other:			

10. Have you ever had a breast biopsy? Yes No

    How many? _____

11. Have you ever had a hysterectomy? Yes No

At what age? _____

12. Have you ever had an oophorectomy (removal of ovaries)? Yes No

At what age? _____

13. Have you ever had colon polyps? Yes No

If yes, how many? _____

Reproductive History:

14. How old were you when you got your first menstrual period? _____

15. Are you still having periods? Yes No

If no, approximately when was your last period? _____

16. How many pregnancies have you had? _____

17. How old were you when you gave birth to your first child? _____

18. Have you ever used birth control pills? Yes No

If yes, for how long? _____

19. Have you ever used hormone replacement therapy? Yes No

If yes, when? _____ For how long?_____