

EXISTING PATIENT HISTORY FORM

Name: _____ Age: _____ Date: _____

Marital/Relationship Status _____

Occupation: _____ Partner's Name: _____

Referred by: _____ Primary MD: _____

Reason for visit: _____

GYNECOLOGICAL HISTORY:

Menstruation: Age your periods started _____ First day of last period _____
Are periods regular? **Y N** Length of cycle _____
Degree of flow: **Light Med Heavy** [Change tampons every ___ hours.]
Pain with periods? **No Some A lot** Medication taken for pain? **Y N**
Menstrual tension or mood swings? **Y N**

PAP smear: Date of last PAP smear: _____ Result _____
Have you had abnormal Pap smear? **Y N** Describe _____

Contraception: Current type: [include condoms, tubals etc.] _____
How long used? _____ Satisfied with method? **Y N**
Have you tried anything different? _____

Sexual History: Sexual preference: **Men Women Both**
Currently sexual active? **Y N** Virginal? **Y N**
How long in current relationship? _____ Age at first intercourse _____
Total # of partners _____ Have you been abused? **Y N**

Vaginal infections: Do you currently have discharge? **Y N**
Describe: _____
Are you having pain with intercourse? **Y N**
Please check any previous infections: Herpes _____ Syphilis _____ Gonorrhea _____
Chlamydia _____ Genital Warts [HPV] _____ Trichomonas _____ PID _____
Do you want to be tested for sexually transmitted infections today? **Y N**

Menopause: [if applicable] What age did it begin? _____
Do you have hot flashes? **Y N** Frequency? _____
Do you have mood swings? **Y N** Frequency _____
Do you have any other symptoms? **Y N** Taking meds for them? **Y N**

Urinary problems: Do you have leakage of urine? **Y N**
Is it during cough or laughing? **Y N** Do you have urgency? **Y N**

Bowel problems: Do you have constipation? **Y N Blood in stool? Y N**
Do you have leakage of stool? **Y N**

Any changes in your medical history since last visit? [New diagnoses, hospitalizations, etc]

HEALTH MAINTENANCE:

Do you exercise regularly? **Y N Sometimes** [1-3 x week]
 Smoking cigarettes? **Y N** Amount _____ Alcohol use? **Y N** Amount _____
 When was last cholesterol screening? _____ Was it normal? _____
 How many 8 oz servings of milk or yogurt daily? _____
 Do you take calcium supplements? **Y N** Do you take vitamins? **Y N**
 Do you perform self breast exam monthly? **Y N Sometimes**
 Have you had mammogram? **Y N** Date of last mammo _____
 Was it normal or abnormal? _____
 If abnormal, describe: _____
 Have you had colonoscopy? **Y N** Date: _____
 Have you had bone density screening? **Y N** Date: _____
 Results: _____

CURRENT MEDICATIONS: [include herbs and vitamins]

Name/location of Pharmacy: _____

Name	Strength	How often taken?

ALLERGIES to medications:

Name of drug	Type of reaction

OTHER CURRENT PROBLEMS: [please check any that are appropriate]

<ul style="list-style-type: none"> <input type="radio"/> Recent weight change <input type="radio"/> Feeling panicked/anxious <input type="radio"/> Decreased interest in sex <input type="radio"/> Increased stress <input type="radio"/> Feeling of hurting yourself <input type="radio"/> Change in sleep patterns <input type="radio"/> Change in eating habits <input type="radio"/> New headaches 	<ul style="list-style-type: none"> <input type="radio"/> Decrease in energy level <input type="radio"/> Lack of interest in activities <input type="radio"/> Pain/discomfort <input type="radio"/> Chest pain <input type="radio"/> Shortness of breath <input type="radio"/> Blood in stools or urine <input type="radio"/> Dizziness
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FAMILY HISTORY QUESTIONNAIRE FOR HEREDITARY CANCER SYNDROMES

Name: _____ Date: _____

The purpose of this questionnaire is to help determine if your family history could indicate the presence of a gene mutation for certain cancers. People who have inherited certain gene mutations are at extreme risk of these cancers. Testing for gene mutations in those people with a concerning family history is important because it has been proven to save lives. Once a gene mutation is diagnosed, much earlier testing and treatment can be started. This can catch cancer at the earliest possible stage (greatly increasing survival) or prevent cancer altogether.

If gene testing is recommended by your doctor, it is typically covered by most insurance companies. Also, laws prohibit health insurance companies from penalizing you if you have a gene mutation.

It is important to remember that most people who get cancer do not have a gene mutation! **MOST CANCERS OCCUR BY CHANCE** in people who have little or no cancer in their family. Therefore, it is important to continue to follow your doctor's recommendations for cancer screening (such as routine mammograms and breast exams) regardless of your family history.

SCREENING FOR HEREDITARY BREAST AND OVARIAN CANCER SYNDROME (BRCA1 AND BRCA2 MUTATIONS):

Y N Have **YOU** had breast cancer? If so, at what age were you first diagnosed? _____
Y N Have **YOU** had ovarian cancer? If so, at what age were you first diagnosed? _____

Please list everyone in your **MOTHER'S** family with breast and/or ovarian cancer and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.)

Please list everyone in your **FATHER'S** family with breast and/or ovarian cancer and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.)

Y N Has anyone had breast cancer in **BOTH** breasts in your **MOTHER'S** OR **FATHER'S** families? If so, who? _____ At what age? _____
Y N Have there been any **MALES** in your **MOTHER'S** or **FATHER'S** families with breast cancer? Who? _____ At what age? _____
Y N Are you of Ashkenazi Jewish ancestry?

SCREENING FOR LYNCH SYNDROME (FORMERLY CALLED HEREDITARY NONPOLYPOSIS COLORECTAL CANCER OR HNPCC):

Y N Have **YOU** had cancer of the uterine, colon, stomach, kidney/urinary tract, brain, or small intestine? If so, circle which ones. If so, at what age diagnosed? _____

Please list everyone in your **MOTHER'S** family with any of these cancers and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.)

Please list everyone in your **FATHER'S** family with any of these cancers and their **AGE** when first diagnosed. (If their age at diagnosis is unknown to you, estimate if they were less than 50 yrs old or older than 50 yrs old.)

Please list everyone in your **MOTHER'S** or **FATHER'S** families found to have 10 or more colon polyps.

Signature

Health Care Provider's Signature

INFORMED CONSENT FOR MAMMOGRAMS AND BLOOD TESTS

YOUR LAB WORK AND/OR MAMMOGRAM MAY OR MAY NOT BE COVERED BY YOUR INSURANCE PLAN. YOU ARE RESPONSIBLE FOR DETERMINING INSURANCE COVERAGE FOR THESE TESTS AND ANY PAYMENTS TO OUTSIDE LABORATORIES AND FACILITIES WHICH PERFORM TESTS FOR YOU.

Please read the following tests below. Check the group of tests that you would like to have drawn during your visit or you can circle the individual test(s) if you do not want the group of tests performed.

____ **Screening Blood Work** (Comprehensive Metabolic Panel, Complete Blood Count, Lipid Panel, Thyroid Panel)

____ **Sexually Transmitted Diseases** (Blood Work: Hepatitis Panel (A, B, C), RPR (Syphilis), Herpes Simplex I & II)
(Cervical Testing: Gonorrhea, Chlamydia)

____ **HIV-1 Antibody** (I understand that the performance and results of the HIV antibody test are considered confidential. I understand that the test results in my health record shall not be released without my expressed written permission except to the individuals and organizations that have been given access by law, who also are required to keep my health information confidential. These include me, my physician, health care facility staff who provide my health care or handle specimens of my body fluids or tissues, funeral directors, court of record under lawful order and the Health and Human Services Department/Travis County Health Department as required by law.)

____ **Annual Mammogram** (Baseline for patients age 35-39, age 40 and over yearly, as needed for family history of abnormal)

____ **Bone Density** (Recommended usually every 24 months once menopausal or at risk for bone loss)

____ **Other** (List any other tests/procedures you would like to have done on the line below)

*****Please note: It is our policy for the PAP test to be performed with HPV typing in order to enhance the detection of cervical dysplasia/cancer in patients 30 years of age and above. If you have questions on HPV testing please discuss with the nurse or provider during your visit.**

I have read the information above and understand its content. I understand that I may ask questions at any time regarding the tests above. I hereby give my consent to have my blood drawn for the following lab(s) listed above that I have checked/circled.

Printed Name: _____ Date: _____

Signature: _____