Name_____ Age:_____ Date:_____ **NEW PATIENT**

Reason for Visit:_____
Pharmacy Name and Number:_____
Referred by/Primary Care Physician:_____

Past Medical History (check all that apply):

Blood Clots/DVT____ Abnormal Pap Smear_____ Epilepsy_____
Hypertension _____ Abnormal Mammogram_____ Diabetes_____
Osteoporosis_____ Breast Cancer _____
Explain:_____

Other Medical History:_____

Date of :	**Result (if abnormal, explain):**
Last Pap Smear:_____	Normal / Abnormal_____
Mammogram:_____	Normal / Abnormal_____
Bone Density:_____	Normal / Abnormal_____
Colonoscopy:_____	Normal / Abnormal_____

Past Surgical History :

Medications :list ALL medications you are currently taking, including dose
(include prescription patches, creams, and over the counter medications)

Allergies: Do you have any drug allergies? N / Yes, please list:_____

Other Allergies:_____

Family History(check all that apply and explain):
List family member and if maternal or paternal

_____Cancer (include type):_____
_____Heart Disease:_____
_____Diabetes:_____
_____Other Family Medical History:_____

Social History:

Do you smoke?_____If yes, packs per day_____ Do you drink alcohol?_____How many times in the past year have you had 4 or more drinks in a day?_____Use illicit drugs?_____
Marital Status:_____Have you experienced depression or domestic violence?____Please explain (confidentiality is guaranteed)_____

Reproductive History:

Date of last menstrual period:_____ Age at first menstrual period:_____
If period has stopped, age at last period:_____ Sexually Active? Yes / No
Type of Contraception:_____
Are your period regular? Yes_____If no, please explain:_____
Do you experience clots while menstruating? No___If yes, please explain:_____
Do you have problems with break through bleeding? No___If yes, please explain:_____
_____
Are you on Hormone Replacement Therapy? Yes_____No_____

Total Pregnancies		Full Term Births		Premature Births	
Abortions		Miscarriages		Ectopic Pregnancies	

	First Name	Date of Birth	Birth Weight	M /F	Doctor's Name	Delivery Method	Complications
1							
2							
3							
4							
5							
6							
7							

Please circle all of the symptoms you are CURRENTLY experiencing:

Constitutional	Fatigue	Weight Loss	Weight Gain
	Loss of Appetite		
HENT	Headaches	Thyroid Mass	
Breasts	Lumps	Tenderness	Swelling
	Redness	Nipple Discharge	Changes in Breast Size
Cardiovascular	Chest Pain	Irregular Heart Beat	Limb Swelling
Respiratory	Shortness of Breath	Wheezing	Cough
Gastrointestinal	Nausea	Vomiting	Diarrhea
	Constipation	Abdominal Pain	Hemorrhoids
Genitourinary	Urgency	Frequency	Decreased Libido
	Vaginal Discharge	Possible Pregnancy	Significant PMS
	Difficulty Urinating	Leaking Urine	Pain with Urination
	Menstrual Irregularities	Menstrual Cramping	
Integument/Skin	Rash	Itching	Hair Growth Change
	Changes to Existing Skin Lesions or Moles	Acne	
Musculoskeletal	Joint Pain	Back Pain	Hip Pain
Endocrine	Loss of Hair	Cold Intolerance	Night Sweats
	Hot Flashes		
Psychiatric	Anxiety	Depression	Difficulty Sleeping
Heme-Lymph	Easy Bleeding	Easy Bruising	

Family History for Common Hereditary Cancer Syndromes

Patient Name_____ **Circle One: Falany / Lawrence / Clardy**

Date of Birth _____ **Date** _____

Have you previously had genetic testing (Example, BRCA) **Y** **N**

If yes, when?_____ What were the results?_____

Please circle Y to those that apply to **YOU and/or YOUR FAMILY** (on both **MOTHER** or **FATHER'S** side.)
Please list your relationship to the individual diagnosed and the age at cancer diagnosis. This is a screening tool for the common features of hereditary cancer syndromes. Based on the family history information you provide here, you MAY be appropriate for genetic testing. Ask your health care provider for additional information.

Consider YOURSELF, PARENTS, SIBLINGS, GRANDPARENTS, AUNTS, UNCLES, NIECES, & NEPHEWS

BREAST AND OVARIAN CANCER

			Relationship	Age at Diagnosis
Breast cancer at or before age 45	Y	N		
Ovarian cancer at any age	Y	N		
Breast cancer in both breasts	Y	N		
Male breast cancer at any age	Y	N		
2 breast cancers on the same side of the family with one diagnosed at/under 50	Y	N		
3 or more breast cancers on the same side of the family at any age	Y	N		
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y	N		

COLON AND ENDOMETRIAL (UTERINE) CANCER

Endometrial (uterine) cancer before age 50	Y	N		
Colorectal cancer before age 50	Y	N		
Colorectal or endometrial (uterine) cancer at any age with two family members on the same side of the family with any cancer listed below*	Y	N		

*Colorectal, Endometrial, Ovarian, Stomach, Pancreatic, Kidney/ Urinary Tract, Brain, or Small Bowel

FOR OFFICE USE ONLY

Candidate for testing? ☐ Yes ☐ No

Patient offered genetic testing ☐ Accepted ☐ Declined

_____ _____

Patient Signature Date Provider Signature Date