unitedregional
physician group

Patient Name: _____

New Patient Questionnaire

What is the reason for your visit?

_____

Who is your family doctor? _____

What was the first day of your last period? _____

What form of birth control do you currently use? _____

Are you currently sexually active?_____

Have you ever been pregnant? Please list number of pregnancies:_____

Miscarriages: _____ Abortions: _____ Live Births: _____

Fill in information in table below for each pregnancy (whether the child is living or deceased). Please start with your first one. Also please list under delivery type if forceps or a vacuum were used.

Year	Weeks	Labor Length	Birth wt.	sex	Type of Delivery (Vaginal or Cesarean Section)	Anesthesia

Please also include a list of any complications you may have had with the pregnancy.
(high blood pressure, diabetes, forceps or vacuum delivery)

_____

_____

When was your last pap smear? _____

Have you ever had an abnormal pap? If so,when?_____

If you have had an abnormal pap, have you ever had any of the following?
(please include the date)

COLPOSCOPY_____ LEEP_____ CRYO THERAPY_____

Are you having any urinary leakage? _____

When was your last mammogram? _____

When was your last colonoscopy? _____

Why did you have one? _____

Have you ever had a bone density scan and if so, when? _____

History

Do you have any of these medical problems? If **YES** please circle.

Eyes	- cataracts, glaucoma, glasses/contacts, macular degeneration, other _____
Ear, Nose & Throat	- allergies, sinusitis, dental abscess, swollen glands, Chronic sore throat, TMJ
Heart	- high blood pressure, irregular heart beat, heart failure, heart attack, CAD
Lungs	- asthma, emphysema, COPD, pneumonia, sleep apnea, cancer
Stomach & Intestines	- reflux, ulcers, irritable bowel, diverticulosis, constipation, cancer
Urinary	- urine incontinence, prostate disease, sexually transmitted disease, kidney stones
Muscles & Joints	- arthritis, pain in arms/legs/neck/back, radiating pain
Brain & Nerves	- seizures, headache, migraines, stroke, Parkinsonism, dementia
Skin	- acne, eczema, psoriasis, hives, cancer, other: _____
Hormones	- diabetes, thyroid, high cholesterol, menopausal, osteoporosis, gout
Blood	- anemia, bleeding, blood clots, cancer
Psychiatric	- depression, anxiety, bipolar, schizophrenia, other: _____

Please list any other medical issues you have currently not listed above_____

_____

_____

_____

Have you had any surgeries? If YES, please list below

Surgery	Age	Physician	Year

Please list any other medical providers involved in your care:_____

_____

_____

Are you currently taking any medicines? If **YES** please list below, or provide a current list

Name of Medication	Medicine dose	How many times each day?	For what condition?

Are you allergic to any medications?_____ If **YES** please medication and reaction below

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Pharmacy of Choice_____

Family's Medical History

	Mother	Father	Sister	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Alcoholism								
Anxiety								
Arthritis								
Asthma								
Cancer & Type								
Depression								
Diabetes								
Heart Disease								
Hyperlipidemia								
Hypertension								
Kidney Disease								
Osteoporosis								
Seizures								
Stroke								
Thyroid Disease								

Social History Information

Are you adopted? (Y/N) Do you have children? (Y/N)

Tobacco Use: ___Current ___Former___Never Type_____ Units per day_____ Duration_____

Alcohol Use: ___Current ___Former___Never Type _____ Units per day_____ Duration_____

Caffeine Usage Daily_____ Type_____

Do you have an Advance Directive? (Y/ N)

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name	Date of Birth	Age

Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close bood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents,Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU Age of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	RELATIVES on your MOTHER'S SIDE	Age of Diagnosis	RELATIVES on your FATHER'S SIDE	Age of Diagnosis
X Y O N	*Example: Breast Cancer*	*45*	*------*	*------*	*Aunt, Cousin*	*45 61*	*Grandmother*	*53*
O Y O N	Breast cancer *(Female or Male)*							
O Y O N	Ovarian cancer *(Peritoneal/Fallopian tube)*							
O Y O N	Endometrial (*Uterine*) cancer							
O Y O N	Colon/rectal cancer							
O Y O N	10 or more Lifetime Colon/ Rectal Polyps *(Specify #)*							
O Y O N	Other Cancer(s) *(Specify cancer type)*	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate						

O Y O N	Are you of Ashkenazi Jewish descent?
O Y O N	Are you concerned about your personal and/or family history of cancer?
O Y O N	Have your or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible) If Yes, Who? _____ What gene(s)? _____ What was the result? _____

What age were you when you started your first period? ____

Age at the time of your first birth: _____

Have you ever had breast biopsies done? YES/NO

Have you gone through menopause? At what age did you enter menopause? _____

Have you ever used hormone replacement therapy or are you currently on hormone replacement therapy? YES/ NO

If so, for how long? _____years

How many sisters do you have? _____

How many sisters did your mother have? (Maternal aunts) _____ How many sisters did your father have? (Paternal aunts) _____

**This questionnaire will be reviewed by a provider within United Regional You and your physician will be contacted if you meet national criteria for genetic evaluation. If you choose or your physician requests, you will be offered a consultation appointment to discuss the history provided. Please indicate if you DO or DO NOT consent to this provider review.	O YES O NO Signature _____ Date _____

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature	**Date**

Office Use Only

Patient offered hereditary cancer genetic testing? O YES O NO O ACCEPTED O DECLINED

If Yes, which test? O BRACAnalysis with Myriad myRisk O Multi 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk

O COLARIS with Myriad myRisk O COLARIS AP with Myriad myRisk O Single Site Testing O Myriad myRisk Update

O Other: _____

Follow-up appointment scheduled? O YES O NO Date of Next Appointment: _____