

**Personal Medical History**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of visit: \_\_\_\_\_

**For Female Patients:*****Hormone/Reproductive History:***

1. At what age did you start your menstrual periods? \_\_\_\_\_
2. Are you still having menstrual periods?  No  Yes  
If no, at what age did they end? \_\_\_\_\_
3. Do you have biological children?  No  Yes  
If yes, at what age did you have your first child? \_\_\_\_\_
4. Have you had your ovaries surgically removed?  No  Yes  
If yes, when? \_\_\_\_\_
5. Have you had your uterus surgically removed?  No  Yes  
If yes, when? \_\_\_\_\_
6. Have you ever taken estrogen hormone replacement?  No  Yes  
If yes, for how long? \_\_\_\_\_
7. Have you ever taken oral contraceptives?  No  Yes  
If yes, for how long? \_\_\_\_\_

***Cancer Screening History:***

8. Have you ever had a mammogram?  No  Yes  
If yes: When was your last mammogram? \_\_\_\_\_  
How often do you have mammograms? \_\_\_\_\_
9. Have you had breast biopsies?  No  Yes  
If yes: List the total number of biopsies you've had: \_\_\_\_\_  
Did any show precancerous changes?  No  Yes  
Did any show cancerous changes?  No  Yes

**For ALL Patients:*****Cancer Screening History:***

10. Have you had colon screening?  No  Yes  
If yes, list the year of your last screening: \_\_\_\_\_
11. Have you had colon polyps?  No  Yes  
If yes, list the total number, if known: \_\_\_\_\_
12. What additional routine cancer screening do you do? \_\_\_\_\_

***General Medical History:***

13. Have you ever had surgery (other than dental, joint repair, or for a bone fracture)?  No  Yes  
If yes, what kind(s) and at what age? \_\_\_\_\_
14. Have you ever received radiation treatment?  No  Yes  
If yes, when? \_\_\_\_\_
15. Do you smoke now or have you in the past?  No  Yes  
If yes, for how many years? \_\_\_\_\_
16. Do you consume alcohol?  No  Yes  
If yes, how many drinks per week? \_\_\_\_\_
17. Do you exercise?  No  Yes  
If yes, how often? \_\_\_\_\_

**Family History**

**INSTRUCTIONS**  
**List all family members, including those with AND without cancer.**  
 If your family is very large, you may photocopy or add more sheets of paper.  
 If exact age is not known, give an approximate age or age range.

1. Are you adopted?  No  Yes If yes, include what you know about your biological family below.
2. What is your ancestry/ethnic background (part of the world your family originally came from)?  
 Mother's side: \_\_\_\_\_  
 Father's side: \_\_\_\_\_
3. Is your family Ashkenazi Jewish?  No  Yes  
 If yes, please indicate which side of the family:  mother's  father's  both
4. If any family members have had cancer genetic testing, please indicate their name, relation to you, and the results here. **Please include a copy of their genetic test report.**

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5. Have you ever had cancer genetic counseling? If so, where? If you have had cancer genetic counseling outside of Allina/VPCI, please complete a release of information form so we can request these records from this facility.

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**EXAMPLE**

	FIRST NAME	AGE	SEX M/F	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
EXAMPLE	Jane	52	F	Breast	49		
EXAMPLE	Margaret		F			85-90	Old age
EXAMPLE	Bob	70	M	Prostate	60s		
EXAMPLE	Mary		F			50s	Unknown

**You**

	PREFERRED NAME	AGE	CANCER(S)	AGE AT DIAGNOSIS
You				

**Your Children**

Are all of your children full siblings (share the same mother and father)?  Yes  No  N/A

	FIRST NAME	AGE	SEX M/F	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Your Children 1							
2							
3							
4							
5							
6							

**Your Siblings**

Are any of your siblings half-brothers or half-sisters to you?  No  Yes  N/A

If yes, indicate in the table below, beside each half-sibling, whether you share the same mother or father.

	FIRST NAME	AGE	SEX M/F	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Your Brothers and Sisters 1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

**Your Nieces and Nephews**

	FIRST NAME	AGE	SEX M/F	NAME OF YOUR SIBLING WHO IS THE PARENT	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

**Your Mother's Family**

Are any of your mother's siblings half-brothers or half-sisters to her?  No  Yes  N/A

If yes, indicate in the table below, beside each half-sibling, whether they share the same mother or father.

	FIRST NAME	AGE	SEX M/F	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Your Mother			F				
Your Mother's Mother			F				
Your Mother's Father			M				
Your Mother's Siblings 1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

**The children of your mother's brothers and sisters (your maternal first-cousins)**

	FIRST NAME	AGE	SEX M/F	NAME OF YOUR AUNT/UNCLE WHO IS THE PARENT	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

**Your Father's Family**

Are any of your father's siblings half-brothers or half-sisters to him?  No  Yes  N/A

If yes, indicate in the table below, beside each half-sibling, whether they share the same mother or father.

	FIRST NAME	AGE	SEX M/F	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
Your Father			M				
Your Father's Mother			F				
Your Father's Father			M				
Your Father's Siblings 1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

**The children of your father's brothers and sisters (your paternal first-cousins)**

	FIRST NAME	AGE	SEX M/F	NAME OF YOUR AUNT/UNCLE WHO IS THE PARENT	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

**Other family members with cancer that are NOT listed above**

	FIRST NAME	RELATIONSHIP TO YOU (ex. mother's mother's sister)	AGE	SEX M/F	CANCER(S)	AGE AT DIAGNOSIS	AGE AT DEATH	CAUSE OF DEATH
1								
2								
3								
4								
5								
6								
7								

6. If any family members have had colon polyps, please indicate their name, relation to you, and the total number of polyps here:

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7. Are there any other concerns you want addressed during your visit?

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