MICHIGAN MEDICINE Rogel Cancer Center **Health History Questionnaire – Cancer Genetics**	MRN: NAME: BIRTHDATE: CSN:

Date of appointment _____/_____/________ (mm/dd/yyyy)

Best Phone # ____________________________ Email address ________________________________

Best Time(s) to contact ____

Past Cancer History (please check any cancer problems that you have had in the past)

☐Bladder cancer	☐Esophageal cancer	☐Prostate cancer
☐Bone cancer	☐Leukemia	☐Skin cancer
☐Brain cancer	☐Lung cancer	☐Small intestine cancer
☐Breast cancer	☐Lymphoma	☐Stomach cancer
☐Cervical cancer	☐Ovarian cancer	☐Uterine cancer
☐Colon cancer	☐Pancreatic cancer	☐Other cancer (list): ____________

Cancer Diagnosis and Treatment

Type of Cancer	Type of Treatment
	Surgery ☐No ☐Yes (what kind?) ____________________________ Chemotherapy ☐No ☐Yes (what agents?) __________________________ Radiation ☐No ☐Yes (to where?) ______________________________ Hormonal Therapy ☐No ☐Yes Other (specify): ____ Where was your cancer treated? ____
	Surgery ☐No ☐Yes (what kind?) ____________________________ Chemotherapy ☐No ☐Yes (what agents?) __________________________ Radiation ☐No ☐Yes (to where?) ______________________________ Hormonal Therapy ☐No ☐Yes Other (specify): ____ Where was your cancer treated? ____
	Surgery ☐No ☐Yes (what kind?) ____________________________ Chemotherapy ☐No ☐Yes (what agents?) __________________________ Radiation ☐No ☐Yes (to where?) ______________________________ Hormonal Therapy ☐No ☐Yes Other (specify): ____ Where was your cancer treated? ____

FOR OFFICE STAFF: COLLECTED INFORMATION MUST BE ENTERED IN MICHART. DISCARD FORM AFTER ENTRY, USING CONFIDENTIAL RECYCLE. DO NOT SEND TO HIM.

97-10059	VER: A/19 HIM: 04/19	**Do Not File**	MICHIGAN MEDICINE UNIVERSITY OF MICHIGAN	NOT A MEDICAL RECORD DOCUMENT

Replaces: 50-10071

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Past Medical History (please check any medical problems that you have had in the past)**:**

☐Bleeding disorder	☐Hearing loss	☐Seizures
☐Bowel problems	☐HIV/AIDS	☐Skeletal/limb abnormality
☐Cardiac disease	☐Hypertension (high blood pressure)	☐Stroke
☐Circulation problems	☐Kidney disease	☐Thyroid disease
☐Diabetes mellitus	☐Liver disease	☐Varicose veins
☐Gastrointestinal abnormality	☐Lung or breathing problems	☐Vision problems

Other _____

Past Surgical History (Check any surgeries you have had and the date of surgery if you know it)**:**

☐Abdominal surgery	☐Orthopaedic surgery	☐Splenectomy
☐Eye surgery	☐Ovary removal	☐Thymectomy
☐Heart surgery	☐Pancreatectomy	☐Thyroid surgery
☐Hernia repair	☐Parathyroid surgery	☐Tonsillectomy
☐Hysterectomy	☐Partial kidney removal	☐Tubal ligation
☐Kidney removal	☐Prostate surgery	☐Vasectomy
☐Lobectomy of lung	☐Septoplasty	☐Whipple surgery
☐Myringotomy	☐Skin lesion excision	☐Other _____

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Health History Questionnaire – Cancer Genetics

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Social History

Marital Status: ☐Divorced ☐Legally Separated ☐Married ☐Significant other ☐Single ☐Widowed ☐Unknown ☐Other specify): _____

I currently live: ☐Alone ☐With family ☐With friends ☐With significant other

Do you have children? ☐No ☐Yes: Ages _____

What is your occupation? _____

Do you ever drink alcohol? ☐Yes ☐No

If yes, please indicate the quantity per week of each:

- Glasses of wine _____
- Cans/bottles of beer _____
- Shots of liquor _____
- Drinks containing 0.5 oz of alcohol _____

Are you sexually active? ☐Yes ☐No ☐Not currently

If yes, is/are your partner(s): ☐Male ☐Female ☐Both

Type of birth control/protection currently used:

☐Not having sex (Abstinence) ☐Condom ☐Injection ☐IUD (Intrauterine device)
☐Oral Contraceptives (Pill) ☐Patch ☐Post-menopausal ☐None
☐Other specify): _____

Do you use drugs? ☐Yes ☐No

If you use drugs, how many times per week? _____

What type(s) of drugs do you use? _____

Tobacco Use History

Check one of the following about smoking tobacco:

☐Never smoked
☐Former smoker
☐Smoke some days
☐Smoke every day
☐Exposed to second hand smoke

If you smoke or used to smoke, how many packs do/did you smoke per day? _____

How many years did you smoke/have you smoked? _____

If you quit, when did you quit? _____

Do you use "smokeless tobacco"? (Select one below)

☐Never used

☐Former user ☐Current user
Type? ☐Snuff ☐Chew

If you quit, when did you quit? _____

Are you ready to quit smoking and / or using smokeless tobacco? ☐Yes ☐No

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Ethnicity

1. **Do you consider yourself to be Hispanic or Latino? (See definition below.) Select one.**
   Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."
   - ☐ **Hispanic or Latino**
   - ☐ ***Not* Hispanic or Latino**
   - ☐ **Unknown**

Race

2. **What race do you consider yourself to be? Select <u>one or more</u> of the following:**
   - ☐ *American Indian or Alaska Native.* A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment.
   - ☐ *Asian.* A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam. (Note: Individuals from the Philippine Islands have been recorded as Pacific Islanders in previous data collection strategies.)
   - ☐ *Black or African American.* A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or African American."
   - ☐ *Native Hawaiian or Other Pacific Islander.* A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
   - ☐ *White.* A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

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Review of Systems: Please check any symptom that you feel currently

Category	Issues	No problems
General	☐appetite change ☐fatigue ☐fever ☐sweats ☐weight loss ☐weight gain ☐weakness	☐
Skin	☐itching ☐rash ☐mole change	☐
Eyes	☐vision change ☐cataracts ☐glaucoma	☐
Ears / nose / mouth	☐dizziness ☐ringing in ears ☐hoarseness ☐sore throat ☐runny nose ☐nosebleeds	☐
Lungs	☐cough ☐shortness of breath ☐chest pain ☐coughing blood ☐wheezing	☐
Heart	☐chest pain ☐palpitations ☐fainting episodes ☐leg pains ☐sleeping with more than one pillow	☐
GI	☐abdominal pain ☐nausea ☐vomiting ☐diarrhea ☐constipation ☐jaundice ☐black stools ☐blood in stools ☐difficulty swallowing ☐hemorrhoids	☐
Genitourinary	☐painful urination ☐increased frequency ☐urgency ☐blood in urine ☐kidney stones ☐urinating at night	☐
Musculoskeletal	☐arthritis ☐stiffness ☐swelling ☐weakness ☐backache	☐
Nervous system	☐headache ☐seizure ☐dizziness ☐tremors ☐memory loss ☐paralysis ☐numbness/tingling ☐anxiety ☐depression ☐personality change ☐suicidal thoughts	☐
Male reproductive	☐testicular pain ☐swelling ☐sexual dysfunction	☐
Female reproductive	☐pelvic pain ☐loss of period ☐abnormal bleeding ☐sexual dysfunction	☐
Hematologic	☐bruising ☐bleeding ☐recurrent infections	☐
Lymph nodes	☐enlargement ☐tenderness	☐

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Patient Provider Information

Family physician:

Name			Specialty
Address			Phone Number
City	State	Zip	Fax

Specialty physician: (e.g., surgeon, oncologist, other)

Name			Specialty
Address			Phone Number
City	State	Zip	Fax
Name			Specialty
Address			Phone Number
City	State	Zip	Fax
Name			Specialty
Address			Phone Number
City	State	Zip	Fax
Name			Specialty
Address			Phone Number
City	State	Zip	Fax
Name			Specialty
Address			Phone Number
City	State	Zip	Fax

To whom should we send information about your visits at Michigan Medicine? _____

_____ _____/_____/_____ (mm/dd/yyyy)

Printed name of person filling out this form Date

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