# HELEN G. NASSIF COMMUNITY CANCER CENTER of IOWA

## Cancer Risk Assessment and Genetics Clinic

You have been scheduled for an appointment on ________________________
Expect your first appointment to last approximately 1 hour.

You will meet with: ☐ Julie Thompson, ARNP
☐ Shana Coker, ARNP

If you are unable to keep your appointment, please call us at **319-369-7816**.

**What to bring:**

- Photo ID
- Insurance Card
- Copays are due at the time of your visit
- Completed family history packet

**Where**: The **Nassif Community Cancer Center** is located on the 2nd floor of the **PCI Medical Pavilion at 202 10th St. SE**.

During your appointment we will be discussing your personal and family medical history. It is very important that you complete this history form to the best of your ability. You may need to contact your family members in order to collect the most accurate information. This information is needed so that we can give you the most accurate information about your cancer risks. Please bring this completed form with you when you come to your first appointment. If you are unable to complete the questionnaire or if you have questions about it, please give us a call. There are many reasons that it may not be possible to complete the entire form. If this is the case, don't worry. We will work through it when you come to your appointment. If you would like to bring someone into your counseling session, we encourage you to bring a support person.

**Information to be gathered:**

- Current age or age at death of all of your relatives up to your grandparents. (children, brothers, sisters, parents, aunts, uncles, 1st cousins, nieces, and nephews)
- If they had cancer, what type of cancer did they have? How old were they at the time of diagnosis?
- Has anyone in the family had genetic testing?

## MEDICAL HISTORY FORM

Name:_______________________________ DOB: ____________________

Marital Status: Married Single Divorced Separated Widowed Other_______

Ethnic Background:____________________________

Past Medical History: (Please circle any that apply to **YOU**)

Heart problems HIV/AIDS Hypertension Stroke Hepatitis

Seizures Kidney/Urine problems Bowel/Stomach problems Diabetes

Bleeding disorders Vision/Hearing problems Bone/Skeletal Problems

Circulation problems Thyroid problems Environmental exposures Other

Please provide further details for any of the diseases you circled above (you may attach extra pages or use the back if necessary):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Past Surgical History: (include type of surgery, date, and hospital)

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Cancer History**

Have you ever been diagnosed with cancer? Y N

Diagnosis: _______________________________________________ Age:_________________

Treatment: ____________________________________________________________________

Institution: ____________________________________________________________________

Second Cancer: ___________________________________________ Age: _________________

Treatment: ____________________________________________________________________

Institution: ____________________________________________________________________

Other cancers: __________________________________________________________________

**Past OB/GYN History (females only):**
Age periods started:________________ Last menstrual period:____________________
Number of births: ____Age at first birth: ____
Are you currently using any form of contraceptives? Y N
If yes, what form are you using: __________________________________________________
Have you used hormonal contraceptives in the past? Y N How many years?___________
Last pap smear: _________________Any abnormal pap smears? Y N When?__________

Do you perform self breast exams? Y N Age at first mammogram: ___________________
Last mammogram:_____________ Number of past breast biopsies: __________________
Any history of abnormal mammograms? Y N If yes, where was it done?______________

Have you had any screening for ovarian cancer? Y N
If **yes**, please answer the following:
Have you had a CA-125 blood test? Y N Date of most recent test: ______________
Results:________________
Have you had a transvaginal ultrasound? Y N Date of most recent scan:_________
Have you had screening for endometrial (uterine) cancer? Y N
If **yes**, please answer the following:
Have you had a transvaginal ultrasound? Y N Date of most recent scan:_________

Have you had a hysterectomy? Y N Age:______Were your ovaries removed? Y N
Age at menopause: _____________
Are you currently using hormone replacement therapy? Y N
Have you ever used hormone replacement therapy? Y N
What is the total amount of time you used these medications? _____years______months
Have you used any natural or herbal products to deal with the symptoms of menopause?
If **yes**, what have you used? _____________________________________________________

**Past Urologic History (males only):**
Have you started prostate cancer screening? Y N
When was your last PSA? __________________ Results:______________________________
When was your last prostate exam? ________________________________________________
Have you ever had an elevated PSA? Y N

**Other Cancer Screening History**
**Colon**
Have you ever had a colon examination? Y N Date: _________________________________
Method of exam: Colonoscopy Flexible Sigmoidoscopy Barium Enema
Stool blood test
Do you have any history of colon polyps? Y N
If **yes**, where was your scope done?__________________________ When?____________

**Skin**
Have you had any pre-cancerous or cancerous moles removed? Y N
Do you see a dermatologist yearly for screening? Y N

**Current Medications (you may bring a list or use the back of this form if needed)**

**Name of medication Dose How often taken Reason for taking**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Social History**

Do you currently use tobacco? Y N

Cigarettes: Amount/day______________ Years used:_____________

Have you used tobacco in the past, but have now quit? Y N

When did you quit? _______________

How many years did you use? _________________

Do you use alcohol? Y N Number of drinks/week:_______________________________________

Occupation: ___________________________ Are you retired? Y N

Have you had any exposure to any chemicals or substances that are known to be harmful (asbestos, radiation, second- hand smoke, DES, etc.)? Y N

If **yes**, what? __________________________________________________________________

**Genetic History**

Have you ever been diagnosed with a genetic condition? Y N

Please list your diagnosis:_____________________________________________________________

Have you ever had a genetic test? Y N

For what condition:____________________________________________________________

What was the result:__________________________________________________________

**Have any of your family members had genetic testing done? If so, what kind, and what were the results?**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

*YOUR CHILDREN*

| Name | Male/ Female | Age at death or current age | Cancer diagnosis | Age at diagnosis | Other medical conditions |
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***YOUR BROTHERS AND SISTERS***

| Name | Male/ Female | Age at death or current age | Cancer diagnosis | Age at diagnosis | Other med. conditions | Your brothers' and sisters' children |
|---|---|---|---|---|---|---|
| | | | | | | # daughters:_______________ Ages:____________________ # sons:____________________ Ages:______________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |

***YOUR MOTHER'S FAMILY*** ***YOUR MOTHER'S COUNTRY OF ORIGIN*:**___________________________________

| Name | Male/ Female | Age at death Or current age | Cancer diagnosis | Age at diagnosis | Other med. conditions | Aunt's and uncle's children |
|---|---|---|---|---|---|---|
| Your mother | F | | | | | |
| Your mother's mother | F | | | | | |
| Your mother's father | M | | | | | |
| Your mother's brothers and sisters | | | | | | # daughters:________________<br>Ages:_____________________<br># sons:____________________<br>Ages:_____________________ |
| | | | | | | #daughters:________________<br>Ages:_____________________<br># sons:____________________<br>Ages:_____________________ |
| | | | | | | #daughters:________________<br>Ages:_____________________<br># sons:____________________<br>Ages:_____________________ |
| | | | | | | # daughters:________________<br>Ages:_____________________<br># sons:____________________<br>Ages:_____________________ |

***YOUR FATHER'S FAMILY*** ***YOUR FATHER'S COUNTRY OF ORIGIN*:**_________________________________

| Name | Male/ Female | Age at death Or current age | Cancer diagnosis | Age at diagnosis | Other med. conditions | Aunt's and uncle's children |
|---|---|---|---|---|---|---|
| Your father | M | | | | | |
| Your father's mother | F | | | | | |
| Your father's father | M | | | | | |
| Your father's brothers and sisters | | | | | | # daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | #daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |
| | | | | | | # daughters:________________ Ages:_____________________ # sons:____________________ Ages:_____________________ |

***OTHER RELATIVES WITH CANCER***

| Name | Male/ Female | Age at death Or current age | Cancer diagnosis | Age at diagnosis | Relationship | Other medical conditions |
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