



## Family Cancer Assessment Clinic (FCAC)

### Medical History Questionnaire

Date Completed: 08 / 01 / 2016

Name: Hailey Erickson Date of Birth: 01 / 15 / 1988

Address: 630 E. Bonita Canyon St.

City: Meridian State: ID Zip: 83646

Home Phone: 949-636-0252 Work Phone: Cell Phone:

Fax: Email: hailey.erickson@gmail.com

Sex: ☒ Female ☐ Male

**Marital status:**

☒ Married ☐ Single ☐ Divorced/Separated/Widowed

**Primary Language:**

☒ English  
☐ Spanish  
☐ Other, please specify: \_\_\_\_\_

**Race:**

☐ American Indian or Alaska Native  
☐ Asian  
☐ Black or African American  
☒ White  
☐ Native Hawaiian or other Pacific Islander  
☐ Unknown  
☐ Unknown-refused

**Ethnicity:**

☐ Hispanic ☐ Unknown-No other info  
☒ Non-Hispanic ☐ Unknown-Refused

**Additional Ethnicity:**

Arab/Middle Eastern? ☐ Yes ☒ No  
Jewish Ancestry? ☐ Yes ☒ No

**Indicate the highest grade or year of school you have completed:**

☐ Never attended school or only kindergarten  
☐ Grades 1-8 (elementary school)  
☐ Grades 9-11 (some high school)  
☐ Grade 12 or GED (high school graduate)  
☐ Vocational/technical school after high school  
☒ Some college, including 2 year degrees  
☐ Bachelors degree  
☐ Masters degree  
☐ Doctoral degree (Ph.D., M.D., J.D., etc)  
☐ Other, please specify: \_\_\_\_\_

**Current Employment Status:** (mark all that apply)

☐ Employed full-time (>30 hrs)  
☐ Employed part-time (<30 hrs)  
☐ Unemployed  
☒ Unemployed but looking  
☐ Retired  
☐ Student  
☐ Not working due to health problems  
☐ Taking care of family  
☐ Other, please specify: \_\_\_\_\_

Years with status: 0

**How many total hours a week are you in:**

school? 0  
work? 0

**If employed, please provide your job title & a brief description of what you do:**

**Do you currently have health insurance coverage:**

☐ Yes ☒ No

**If yes, how is this insurance provided (mark all that apply):**

☐ Provided through current or former employer  
☐ Provided through spouse's or parent's policy  
☐ Through a policy I purchase myself  
☐ Medicare  
☐ Medicaid  
☐ Other, please specify: \_\_\_\_\_  
☐ Don't know

**Medical History** Please check all **previous** and/or **current** illnesses

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bleeding problems   | <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Lung problems           |
| <input type="checkbox"/> Bone or skeletal problems   | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Circulation   | <input type="checkbox"/> Kidney/Urine Problems | <input type="checkbox"/> Thyroid problems        |
| <input type="checkbox"/> Gastrointestinal/Bowel problems                                   | <input type="checkbox"/> Liver problems        | <input type="checkbox"/> Vision/hearing problems |
| <input type="checkbox"/> Development of teeth problems, or extra/missing teeth             |  |  |
| <input type="checkbox"/> Environmental exposures (ex: radiation, chemical exposures) _____ |  |  |

**Please provide a description of your illnesses for the boxes you checked above:**Were you conceived through in vitro fertilization? ☐ Yes ☒ No ☐ Unknown**Current Medications**

Name of Medication	Dose	How Often Taken	Reason for Taking
Phentermine	37.5mg	1 - 2 times/day	weight loss
Chromium Nicotinate	200mcg	1 - 2 times/day	weight loss

**Allergies**Please list any medications, food products, or other things that you are **allergic** to: \_\_\_\_\_**Past Surgical History** (include the type of surgery and date)**Genetic History**Have you been diagnosed with a genetic condition? ☐ Yes ☒ No

If yes, please list your diagnosis: \_\_\_\_\_

Have you ever had a genetic test? ☐ Yes ☒ No

For what condition? \_\_\_\_\_ What was the result? \_\_\_\_\_

Has a family member ever been diagnosed with a genetic condition? ☒ Yes ☐ NoIf yes, please list the condition(s): Li Fraumeni**Cancer History**Have you been diagnosed with cancer (do not include non-melanoma skin cancer)? ☐ Yes ☒ No

Diagnosis: \_\_\_\_\_ Age: \_\_\_\_\_

Treatment: \_\_\_\_\_

At what institution was this cancer treated? \_\_\_\_\_

Second cancer: \_\_\_\_\_ Age: \_\_\_\_\_

Treatment: \_\_\_\_\_

At what institution was this cancer treated? \_\_\_\_\_

Other cancers: \_\_\_\_\_

**Colon Cancer Screening**Have you ever had a colon examination? ☐ Yes ☒ NoHave you ever had an examination of your upper digestive system (stomach): ☐ Yes ☒ No

Please indicate results of your past colon examinations:

Year	Type of Procedure (Colonoscopy, Colectomy, Upper Endoscopy, Sigmoidoscopy)	Number of Polyps	Type (if known)

## Past OB/GYN History (Females Only)

Age period started: 13 Last menstrual period: 07 / 15 / 2016

Age at first birth: 21 Number of births: 2 Number of miscarriages or still births: 0

Any history of infertility: ☐ Yes ☒ No

Ever use birth control pills or hormonal contraception: ☒ Yes ☐ No

If yes, what is the total amount of time used? Years: 0 Months: 7

Year of Last Pap smear: 2012 Any abnormal Pap smears? ☐ Yes ☒ No If yes, When?      /      /     

Have you had a hysterectomy? ☐ Yes ☒ No If yes, at what age?     

Have you had one or both ovaries removed? ☒ No ☐ One ☐ Both If one or both, at what age?     

Age at menopause:     

Have you ever used hormone replacement therapy? ☐ Yes, currently ☐ Yes, but not anymore ☒ No, never used.

If yes, how long have you used/did you use hormone replacement therapy?     

Have you used any natural or herbal products to deal with symptoms of menopause? ☐ Yes ☒ No

If yes, what products have you used?     

Do you perform self-breast exams? ☒ Yes ☐ No

Age at first mammogram:      Last mammogram:      /      /     

Have you ever had a breast biopsy? ☐ Yes ☒ No If yes, date(s) of breast biopsies:      /      /     

Have you had a mastectomy? ☒ No ☐ 1 breast ☐ Both breasts Reason:     

## Past Urologic History (Males Only)

Have you begun prostate cancer screening? ☐ Yes ☐ No

When was your last PSA blood test?      /      /     

Have you ever had an abnormally high PSA level? ☐ Yes ☐ No

## Skin Cancer Screening

How many pre-cancerous moles have you had removed?

- ☒ None ☐ More than 4  
☐ 1-2 ☐ Unsure  
☐ 3-4

Age first pre-cancerous mole removed:     

What is the total number of moles on your body?

- ☐ Less than 5 ☐ Greater than 50  
☒ 5-15 ☐ Unsure  
☐ 15-20

Were you diagnosed with melanoma during pregnancy?

- ☐ Yes ☒ No

What was your natural hair color as an adolescent?

- ☐ Black ☐ Dark Brown ☐ Medium Brown  
☐ Light Brown ☒ Red ☐ Yellow Blond  
☐ White Blond ☐ I don't know

Does your hair have red undertones? ☒ Yes ☐ No

How would you describe your eye color?

- ☒ Blue ☐ Dark Brown ☐ Gray  
☐ Green ☐ Light Brown ☐ Hazel

How many blistering sunburns have you had?

- ☐ None ☐ 1-2 ☒ 3-4  
☐ More than 4 ☐ Unsure

Have you had non-melanoma skin cancers (basal or squamous cell carcinomas)? ☐ Yes ☒ No

How many basal cell carcinomas?      Approximate age first detected:     

How many squamous cell carcinomas?      Approximate age first detected:     

## Social History

Do you drink alcohol? ☐ Yes ☒ No Number of drinks per week:     

Do you use or have you ever used tobacco? ☐ Yes, currently ☐ Yes, but quit ☒ No, never used

If yes, which types?

- |   |                            |                                  |
|---|----------------------------|----------------------------------|
| <input type="checkbox"/> Cigarettes         | Amount per day <u>    </u> | Number of years used <u>    </u> |
| <input type="checkbox"/> Cigars             | Amount per day <u>    </u> | Number of years used <u>    </u> |
| <input type="checkbox"/> Chew tobacco/snuff | Amount per day <u>    </u> | Number of years used <u>    </u> |