HUNTSMAN CANCER INSTITUTE UNIVERSITY OF UTAH

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*

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

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 ☐ No
If 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 ☑ No
Have 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?
☐ Cigarettes Amount per day_____ Number of years used _____
☐ Cigars Amount per day_____ Number of years used _____
☐ Chew tobacco/snuff Amount per day _____ Number of years used _____