Health Questionnaire

Monarch Healthcare
Delivering tomorrows promises, today.

Name _____ Date of Birth _____ Age _____ Date _____

Family Practice Physician _____ Preferred Pharmacy _____

Problems to Discuss During Your Visit:

1. _____ 2. _____
3. _____ 4. _____

Do You Have any Allergies?: *List all allergies including medication, food, skin, environment, etc.*

_____
_____

Current Medications: *List all medications including: Medication, Dosage, Prescriber and Reason for medication.*

_____
_____
_____

Surgery History:

Date	Type of Surgery	Date	Type of Surgery

Pregnancy History: *Include all miscarriages, abortions or tubal pregnancies.*

Date of Delivery	# Weeks at Delivery	Hours in Labor	Birth Weight	Sex	Delivery Type – Vaginal, C-section, Forceps	Complications

Your Medical History: *List current problems, past diagnoses and hospitalizations.*

1.	3.	5.
2.	4.	6.

Examples: Diabetes, Depression, Stroke, Anemia, STDs, High Blood Pressure, Heart Disease, Kidney Disease, Blood Clotting Disorders, Asthma, etc.

Your Family's Medical History: *List current problems, past diagnoses and hospitalizations.*

1.	3.	5.
2.	4.	6.

Examples: Diabetes, Depression, Stroke, Anemia, STDs, High Blood Pressure, Heart Disease, Kidney Disease, Blood Clotting Disorders, Asthma, etc.

Do You Smoke? Yes No How many cigarettes a day? _____
Do You Drink? Yes No How much? _____ Married_____Single_____Widowed_____

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Reproductive History:

Age of 1st Menses _____
Date of Last Period _____
Date of Last Pap Smear _____
Date of Last Mammogram _____
Date of Last Colonoscopy _____
Date of Last Bone Density Scan _____

Have you ever had an abnormal pap smear? Y N

Sexual History:

Are you using any method to prevent pregnancy: Yes No
If Yes which type (please circle)? Pill Tubal Vasectomy Condoms Depo-Provera IUD Diaphragm Rhythm Other _____
Do you have pain with intercourse? Yes No

Instructions: This is a screening tool for cancers that run in families. Please circle Y for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.
You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren.

You & Your Family's Cancer History: (please be as thorough and accurate as possible)

Y / N	CANCER	YOU AGE of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	Relatives on your MOTHER'S SIDE	Age of Diagnosis	Relatives on your FATHER's SIDE	Age of Diagnosis
Y / N	Breast Cancer (female or male)							
Y / N	Ovarian Cancer (Peritoneal/Fallopian Tube)							
Y / N	Uterine (endometrial) Cancer							
Y / N	Colon/Rectal Cancer							
Y / N	10 or more lifetime colorectal polyps (specify #)							
Y / N	Other cancer(s) (specify cancer type)							

Y / N	Are you of Ashkenazi Jewish descent?
Y / N	Are you concerned about your personal and/or family history of cancer?
Y / N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (please explain/include results if possible)

Hereditary Cancer Red Flags: Personal and/or family history of any one of the following:

_	**Multiple** A combination of cancers on the same side of the family:	• **2 or more:** breast/ovarian/prostate/pancreatic cancer • **2 or more:** colorectal/endometrial/ovarian/gastric/pancreatic/other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) • **2 or more:** melanoma/pancreatic
_	**Young** Any 1 of the following at age **50 or younger:**	• Breast cancer • Colorectal cancer • Endometrial cancer
_	**Rare** Any 1 of these rare presentations at **any age:**	• Ovarian cancer • Breast: Male breast cancer or Triple negative breast cancer • Colorectal cancer with abnormal MSI/IHC, or MSI associated histology • Endometrial cancer with abnormal MSI/IHC • 10 or more colorectal polyps