Hawaii Cancer Care

Hereditary Cancer Risk Assessment

Patient Name: _____

Patient Day Time Phone: _____

Most of the time, cancer happens by chance. However, in some families cancer may be caused by change in certain genes that can be passed from generation to generation. These genetic changes significantly increase a person's risk for certain cancers, including a second cancer in those who have been diagnosed. Family members will benefit from this information, as will you, since hereditary cancer risk can be significantly reduced with the right medical interventions. A careful review of your family history is an essential first step, so please check all of the boxes that apply to you:

Have YOU been diagnosed with...	YES	NO	UNCERTAIN
Breast cancer before age 50?	☐	☐	☐
Ovarian cancer at any age?	☐	☐	☐
Two breast cancers, or breast *and* ovarian cancer?	☐	☐	☐
Breast cancer at any age? (Male Gender)	☐	☐	☐
Colon or uterine cancer before age 50?	☐	☐	☐
Colon or uterine at *any* age with family history of either?	☐	☐	☐
Two colon cancers, or colon *and* uterine cancer?	☐	☐	☐
20 or more cumulative colon polyps?	☐	☐	☐
Two or more melanomas?	☐	☐	☐
Melanoma and pancreatic cancer?	☐	☐	☐
Are you of Ashkenazi Jewish Ancestry?	☐	☐	☐

Have any of your FAMILY members been diagnosed with...			**WHO?**
*(Please indicate **maternal** or **paternal** as they are BOTH important)*			
Breast cancer before age 50?	☐	☐	_____
Ovarian cancer at any age?	☐	☐	_____
Two breast cancers, or breast *and* ovarian cancer? *	☐	☐	_____
Breast cancer at any age? (Male Gender)	☐	☐	_____
Colon or uterine cancer before age 50?	☐	☐	_____
Two colon cancers, or colon *and* uterine cancer? *	☐	☐	_____
20 or more cumulative colon polyps?	☐	☐	_____
Two or more melanomas? *	☐	☐	_____
Melanoma and pancreatic cancer? *	☐	☐	_____

* *Can be two cancers in one person, or two or more people in your family with these cancers*If any YES boxes are checked, you have a personal or family history suggestive of one of the more common hereditary cancer syndromes and are a candidate for further risk assessment and, if appropriate, genetic testing to determine if a gene change exists. We will discuss this with you and provide you with additional information that will help you understand your individual risks and how to best address them.

☐ **Candidate for further risk assessment and/or genetic testing** ☐ **Patient offered genetic**

☐ **Information given to patient to review.** ☐ **Accepted** ☐ **Declined**

☐ **Follow up appointment scheduled Date:**

☐ **Patient education DVD distributed to the patient.**

☐ **Patient education tool pamphlet distributed to the patient.**

_____ _____

Patient's Signature Date Health Care Provider's Signature Date

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PATIENT HEALTH SURVEY

Name:_____**Date:**___/____/_____

I. CURRENT MEDICATIONS

Date Started	Drug Name	Dosage	Frequency

Are you **allergic** to any medicine?_____
Are you **allergic** to seafood or Iodine?_____

HERBAL OR COMPLEMENTARY MEDICATIONS

II. SOCIAL HISTORY

Select what best describes your ethnic background (You can check more than one)

O African American
O American Indian, Aleutian, Eskimo
O Asian
- O Chinese
- O Japanese
- O Korean
- O Filipino
- O Vietnamese
- O Indian
- O Laotian

O Caucasian
- O Were any of your relatives of Eastern European Jewish (Ashkenazi) descent?_____

O Hispanic
O Puerto Rican
O Pacific Islander
- O Hawaiian
- O Samoan
- O Tongan
- O Chamorro
- O Micronesia
- O Fijian

O Other: _____

What is your highest level of education? (Please choose only one response)

O Some grade school
O Some high school
O High school graduate
O Vocational or technical school
O Some college or associate degree
O College graduate
O Graduate or professional school
O Other_____

Are you 1st generation, 2nd generation, 3rd or more generation in America?_____
Marital Status (Married, Divorced, Widowed, Separated): _____
Living situation (Independent, Family, Nursing Home):_____

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Current Job or Previous Occupation: _____

O Employed 32 hours or more per week
O Employed less than 32 hours per week
O Employed less than 32 hours and student
O Unemployed or seeking work
O Full time or Part time student
O Retired
O Homemaker
O Disabled
O On medical leave
O Other

III. SMOKING, ALCOHOL & DRUG HISTORY

O Have your ever smoked?
O Yes; but only in the past
O Yes; currently
O No; never.

If you have ever smoked, what did you smoke? choose all that applies.
O Cigarettes O Cigars O Pipe O Other

If you have ever smoked, on average, how many packs per day did you smoke?

O Never smoked
O Less than ½ pack per day
O 1 pack per day
O 1 ½ packs per day
O 2 packs per day
O More than 2 packs per day

When did you start smoking (about what age)? _____
When did you quit smoking? _____
If you are currently smoking, would you like help stopping?_____
*Advised to quit & Referral to Quit Smoking program (MD initial)*_____

ALCOHOL & DRUG HISTORY

Have you ever or do you currently drink alcohol?
O Yes; but only in the past
O Yes; currently
O No; never

How many alcoholic beverages do you consume weekly? Please approximate the number of beverages per week:
O None
O Beer_____bottles
O Wine_____glasses
O Mixed Drinks_____drinks
O Less than one drink per week

If your alcohol intake in the past was different from now, how many alcoholic beverages did you consume weekly?
O None
O Beer_____bottles
O Wine_____glasses
O Mixed Drink____drinks
O Less than one drink per week

Has anyone suggested you cut down the amount you drink? O Yes O No
Have you needed an "eye-opener" drink in the morning? O Yes O No
Do you feel guilty drinking? O Yes O No
Do you feel angry if someone suggests you stop drinking or cut back? O Yes O No
Have you ever had a DUI? O Yes O No
Do you use recreational drugs?:_____Have you had blackouts? O Yes O No

IV. PHYSICAL ACTIVITY

Do you have a regular exercise activity? O Yes O No
How many times a week?_____
How active are you?
O No Problems; can do most everything I did before getting sick.
O Some problems, but I can walk with assistance.
O I have some limitations, and require help during the day
O I have more problems and sleep more than 50% of the day
O I am in bed almost all of the time.

What hobbies do you have? _____

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V. FAMILY HISTORY

How many brothers do/did you have?_____
How many sisters do/did you have?_____
How many children do/did you have?_____
If adopted, check here_____and leave blank any questions you cannot answer
Do you have any family members with cancer? (Living or Deceased)

Cancer Type	How many relatives?	Relationship to you?	Age (years) at diagnosis?
o Bladder			
o Brain			
o Breast			
o Cervical			
o Colorectal			
o Hodgkin's lymphoma			
o Non Hodgkin's lymphoma			
o Kidney			
o Leukemia			
o Lung			
o Melanoma			
o Mouth or Throat			
o Ovarian			
o Pancreatic			
o Prostate			
o Skin			
o Stomach			
o Thyroid			
o Uterine			
o Other (specify)			
o Unknown			

Are you interested in genetic counseling? O Yes O No

Do you have family members with other illnesses? (Living or Deceased)

Illness	How many relatives?	Relationship to you?
o Diabetes		
o High Blood Pressure		
o Heart Disease		
o Heart Attack		
o Strokes		
o Arthritis		
o Bleeding Problems		
o Anesthesia Problems		
o Huntington's Chorea		
o Other		
o Other		
o Other		

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VI. PAST CANCER HISTORY

Have you ever had cancer in the past? (If not, then please skip this section)
Do you have cancer now? O Yes O No
If yes, has the cancer spread or metastasized to other parts of your body?

Cancer Type	Chemotherapy	Radiation	Surgery	Hormonal Therapy
○ Bladder	○	○	○	○
○ Breast	○	○	○	○
○ Cervical	○	○	○	○
○ Colorectal	○	○	○	○
○ Kidney	○	○	○	○
○ Leukemia	○	○	○	○
○ Liver	○	○	○	○
○ Lung	○	○	○	○
○ Lymphoma	○	○	○	○
○ Melanoma	○	○	○	○
○ Mouth or Throat	○	○	○	○
○ Ovarian	○	○	○	○
○ Prostate	○	○	○	○
○ Skin	○	○	○	○
○ Stomach	○	○	○	○
○ Thyroid	○	○	○	○
○ Uterine	○	○	○	○
○ Other (specify)	○	○	○	○

VII. SURGICAL HISTORY

Please indicate in the table below your history of surgical procedures (if none, then skip this section)

Type of surgery	Date of Surgery	Doctor
○ Hernia repair		
○ Gallbladder removal		
○ Coronary Artery Bypass		
○ Breast Biopsy		
○ Skin biopsy or skin cancer removal		
○ Joint replacement		
○ Hysterectomy		
○ Transplantation		
○ Cataracts		
○ Other (specify)		
○ Other (specify)		
○ Other (specify)		

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VIII. MEDICAL HISTORY

GENERAL SYMPTOMS

1) Have you had weight loss within the past six months? O Yes O No
2) If yes, how much weight have you lost?_____(pounds)
3) Do you have any difficulty sleeping? O Yes O No
4) Have you felt fatigued (tired) within the past 3 months? O Yes O No

EYE DISORDERS

5) Do you wear eyeglasses? O Yes O No
6) Do you have trouble seeing or eye disorders? O Yes O No
(for example blindness, bleeding, cataracts, glaucoma or detached retina?)

EAR, NOSE & THROAT

7) Do you have difficulty hearing? O Yes O No
8) Do you have a history of sinus problems? O Yes O No
9) Do you have a history of voice changes? O Yes O No

CARDIOVASCULAR

10) Have you ever had a heart attack? O Yes O No
11) Have you ever had chest pain (angina)? O Yes O No
12) Do you have high blood pressure? O Yes O No
13) Have you ever been treated for heart failure? O Yes O No
14) Do you have a history of heart arrhythmias (irregular or too fast)? O Yes O No
15) Do you have poor blood circulation in your legs? O Yes O No
16) Do you have swelling of your arm or legs? O Yes O No
17) Do you have high cholesterol or triglycerides in your blood? O Yes O No

RESPIRATORY

18) Do you have coughing or shortness of breath (dyspnea)? O Yes O No
19) Do you have asthma, emphysema, bronchitis, or lung disease? O Yes O No
20) Have you ever had tuberculosis (TB)or a positive skin test (PPD)? O Yes O No
21) If Yes, did you take medications? O Yes O No

GASTROINTESTINAL

22) Have you had any nausea or vomiting recently? O Yes O No
23) Do you have difficulty swallowing or eating? O Yes O No
24) Do you have recent changes in your bowel habits? O Yes O No
(diarrhea or constipation)
25) Do you have blood in your stool? O Yes O No
26) Do you have cirrhosis or serious liver damage? O Yes O No
27) Do you have a history of hepatitis? O Yes O No
28) Do you have stomach ulcers or peptic ulcer disease? O Yes O No
29) Have you had a problem with reflux? O Yes O No

MUSCULOSKELETAL

30) Do you have pain in your joints, arms, legs, or muscles? O Yes O No
31) Do you have arthritis? O Yes O No
32) Has the condition been call “rheumatoid” O Yes O No
33) If yes, do you take medications for it regularly? O Yes O No
34) Do you have lupus or polymyalgia rheumatica? O Yes O No
35) Have you ever had chronic fatigue syndrome? O Yes O No
36) Have you ever had gout? O Yes O No
37) Have you ever had broken bones or compression fractures? O Yes O No

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GENITOURINARY

38) Have you ever had problems with your kidneys? O Yes O No
39) Have you ever had blood in the urine? O Yes O No
40) Have you ever had urinary tract or bladder infections? O Yes O No
41) Do you have urinary incontinence? O Yes O No.
42) For females only. Any vaginal bleeding or abnormal discharge? O Yes O No
43) For females only. How old were you when you started your periods? _____
44) For females only. How many times have you been pregnant? _____
45) For females only. Have you used oral contraceptives in the past? O Yes O No
46) For females only. Have you used hormonal replacement drugs? O Yes O No

SKIN PROBLEMS

47) Do you have skin problems or any rashes? O Yes O No
48) Do you have non-healing skin wounds? O Yes O No
49) Have you ever had skin cancer? O Yes O No

NEUROLOGICAL / PSYCHOLOGICAL

50) Have you had a blood clot or bleeding in the brain? O Yes O No
51) Do you have difficulty moving an arm or leg? O Yes O No
52) Have you ever lost sensation in an arm or leg? O Yes O No
53) Have you ever had a seizure or epilepsy? O Yes O No
54) Do you have a history of mental health problems? O Yes O No
55) Do you have a history of anxiety or depression? O Yes O No
56) Have you taken or taking medications for any mental illness O Yes O No
57) Are you under the care of a mental health professional O Yes O No
58) Do you have Alzheimer's Disease, or any form of dementia? O Yes O No

ENDOCRINE

59) Do you have diabetes or high blood sugar? O Yes O No
60) If yes, is it treated by modifying your diet? O Yes O No
61) By medications taken by mouth? O Yes O No
62) By insulin injections? O Yes O No
63) Has your diabetes caused problems with your kidneys or eyes? O Yes O No
64) Do you have a history of thyroid disease? O Yes O No
65) If Yes, then did you take medications to treat it? O Yes O No

HEMATOLOGIC/LYMPHATIC DISORDERS

66) Do you have leukemia or polycythemia vera or lymphoma? O Yes O No
67) Have you ever had bleeding that would not stop? O Yes O No
68) Do you have hemophilia or von Willebrand's disease? O Yes O No
69) Have you ever received any blood transfusions? O Yes O No

PATIENT EDUCATION

1) Would you like more information about your disease? O Yes O No
70) Are you interested in new therapy or a clinical trial? O Yes O No
71) Do you have an advance directive or living will? O Yes O No

SCREENING: Date: Mo/Yr

Mammogram: _____
Colonoscopy:_____
Pap Smear:_____
DEXA Scan:___

IMMUNIZATION: Date: Mo/Yr

Influenza:_____ Pneumovax:_____Tetanus:_____
Herpes Zoster (Shingles):_____Covid-19: _____

PHYSICIAN REVIEW:

MD Signature and date & time_____/ / / /