Hunterdon Health
Hunterdon Regional Cancer Center
2100 Wescott, Drive, Flemington, NJ 08822
Phone: 1-888-788-1260
www.hunterdonhealth.org

HEALTH HISTORY QUESTIONNAIRE

Family Risk Assessment Program

Name_____ DOB_____ Current Age _____

Address _____

_____

Home Phone_____ Cell Phone_____ Business Phone _____

E-mail Address _____

(Email will not be shared without your request and/or consent)

City, State, Country of Birth _____

Health Care Provider(s) _____

(If one of the above is your PRIMARY care provider, please indicate by circling name)

Signature_____ Date _____

This form will be reviewed with you at your visit and used to help us identify your individual cancer risks and promote discussion about risk reduction strategies.

About Your Family:

(We request this information because some cancer syndromes and cancer risks affect certain ethnic groups more than others.)

	Mother's Family	Father's Family
Countries of origin (you may list more than one)		
Religion (you may list more than one)		
Race, ethnicity (you may list more than one) (ie: Caucasian, African, Hispanic, Asian, Caribbean, Middle Eastern, Native American.		

Your highest level of education completed: Elementary School_____ High School _____

Associate Degree_____ Bachelor Degree _____ Graduate Degree_____

Marital Status: Single __ Married __ Divorced __ Separated __ Civil Union __ Widowed __ Other ____

Biologic sex assigned at birth: _____ Preferred gender identity: _____

Preferred pronouns: _____

Sexual History:

Increased risk for some cancers have been associated with sexual history and lifestyle, such as (but not limited to) multiple sexual partners, same-sex relationships, oral and anal intercourse. Sharing your sexual identity and experiences with us will allow us to better complete your cancer risk assessment. This information remains confidential. **You may choose NOT to respond if you wish.**

Please indicate which of the following best describes you (you may indicate more than one):

	Heterosexual	Gay/ Lesbian	Bisexual	Questioning	Celibate	More than one partner	Do not wish to respond
Past							
Present							

Primary Occupations, past and present: (to help us assess occupational risks).

Have you ever had (or been exposed to) any of the following?

	YES	NO	DON'T KNOW	PLEASE LEAVE THIS COLUMN BLANK
Asbestos				
Second Hand Smoke				
Chemicals, Solvents, Pesticides, Petroleum Products				
Radiation Treatment (even as an infant)				
Sunburns/Salon Use				
DES (a hormonal medication). (Did your mother take it when pregnant with you?)				
Unusual Skin Moles				
Human Papilloma Virus (HPV)				
Hepatitis				
Epstein-Barr Virus (Mono)				
H. Pylori Infection (Stomach)				
Barrett's Esophagus				
Have you ever had intestinal polyps?				
Do you have Ulcerative Colitis or Crohn's Disease?				
Have you ever been exposed to an environmental agent such as Agent Orange (Vietnam), Radiation (Chernobyl), or Inhaled Particulate Matter (World Trade Center)?				
Have you ever used Tamoxifen or Raloxifene ("Evista")?				
Have you ever served in the military?				

Your current height: _____ Your current weight: ____ Allergies: _____

Trends in weight loss or weight gain: _____

_____

	YES	NO	Please provide brief detail	PLEASE LEAVE THIS COLUMN BLANK
Have you been diagnosed with cancer within the past 12 months?				
Have you been diagnosed with cancer previously (more than one year ago)?				
Are you receiving long term treatment for a chronic condition such as heart disease, diabetes, kidney disease, high blood pressure, osteopenia, respiratory problems, mental health, or another condition?				
Have you ever had surgery? If yes, please list all.				
Have you ever had a breast biopsy? If yes, please list dates and results.				
Have you ever had a biopsy of an area other than the breast? If yes, please specify type, date(s), and results.				

Medications:

Please list any current medication you take (include “over the counter” (non-prescription) medications and herbal or dietary supplements). Please include dosage and frequency of use.

_____

_____

_____

Nutrition:

Please describe your diet (ie: “regular”, low fat, vegetarian, high fiber, etc.) _____

Do you drink /consume caffeine? Yes ___ No ___ If yes, what type: _____ servings/day: _____

How many servings of the following do you eat daily? Fruit: _____ Vegetables: _____ Red Meat: ____

Physical Activity:

How many days of moderate to strenuous activity, like a brisk walk, did you have in the past 7 days?

_____

On those days, that you engaged in moderate to strenuous activity, how many minutes, on average, did you exercise? _____

What type of physical activities do you like to do? _____

_____

This Section Helps Us Identify Cancer Risk Factors

Tobacco:

Have you ever used tobacco? Yes ____ No ____ If yes, age started _____ Age stopped_____

Type of tobacco: _____ Usage per day: _____

Have you ever vaped? Yes _____ No _____ If yes, age started _____ Age stopped _____

Passive smoke exposure? Yes _____ No _____ Passive vaping exposure? Yes_____ No _____

Alcohol:

Do you drink alcohol? Yes _____ No _____

Type: _____ Frequency: _____ Amount: _____

When was the last time you drank alcohol? _____

Other:

Please describe your past exposure to X-rays. (If none other than routine dental X-rays, please state “routine dental”) _____

_____

Is there anything else about your personal medical history or exposure history that causes you to perceive your risk for cancer as “higher than the average person”? _____

_____

FOR WOMEN ONLY:

Age you were when your periods began? _____ Age at menopause? (if applicable) _____

Are (were) your periods regular? _____ How many days apart? _____

Have you ever had a full-term pregnancy? Yes _____ No _____

If yes, how old were you at the time or your first full-term delivery? _____

Did you breast feed for a total of more than 6 months? Yes _____ No _____ N/A _____

Have you had gynecologic surgery (including C-section, tubal ligation)? Yes _____ No _____

If yes, please describe _____

Have you ever had fertility treatment? Yes _____ No _____ Cause of infertility? _____

If yes, please describe _____

Have you ever used hormonal contraceptives, such as the pill, patch, shot or implant? Yes __ No ___

If yes, please describe (products used, total length of time used, etc.) _____

_____

Have you used hormone therapy? Yes _____ No _____ Reason _____

If yes, please describe (products used, total length of time used, etc.) _____

_____

Have you ever experienced a pregnancy loss (termination/miscarriage)? Yes_____ No _____

If yes, please describe _____

FOR MEN ONLY:

Have you ever had any fertility problems? Yes _____ No _____

If yes, please describe _____

Have you had a vasectomy? Yes _____ No _____

Have you ever been diagnosed with gynecomastia (enlargement of male breast tissue)? Yes __ No __

Have you ever received hormone treatment? Yes _____ No _____

If yes, please describe _____

CANCER SCREENING HISTORY:

(IF YOU HAVE NEVER HAD A SPECIFIC EXAM, PLEASE INDICATE WITH "NEVER")

		Month/ year of last exam	How often do you have this exam?	Has this exam ever been abnormal? (yes)	(no)	Please leave this column blank
FOR BOTH MEN & WOMEN	**Skin self-exam**					
	Skin exam by a health care provider					
	Oral Screening (usually through routine dental care)					
	Colonoscopy					
	Sigmoidoscopy					
	Barium Enema					
	Testing for blood in stool					

		Month/ year of last exam	How often do you have this exam?	Has this exam ever been abnormal? (yes)	(no)	Please leave this column blank
FOR MEN ONLY	**Prostate Exam (digital rectal exam)**					
	PSA (prostate specific antigen, a blood test)					
	Testicular Self-exam					

FOR WOMEN ONLY		**Month/year of last exam**	**How often do you have this exam?**	**Has this exam ever been abnormal?** (yes)	(no)	**Please leave this column blank**
	Breast Self-exam					
	Breast exam by a health care provider					
	Mammogram					
	Ultrasound of the breast					
	MRI of the breast					
	Pap Smear					
	Pelvic Exam (with or without pap smear)					
	Ca-125 (blood test)					
	Transvaginal Ultrasound					

Mental Wellness: You may decline to answer any of the following questions.

Do you feel stress these days?

Not at all _____ Only a little _____ More than half the days _____ Nearly every day _____

Over the last two weeks, have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?

   Not at all _____ Only a little _____ More than half the days _____ Nearly every day _____

2. Feeling down, depressed, or hopeless?

   Not at all _____ Only a little _____ More than half the days _____ Nearly every day _____

Within the past year have you been emotionally abused by your partner/ex-partner? Yes ___ No ___

Have you been afraid of your partner/ex-partner? Yes _____ No _____

Have you ever been forced to engage in any type of sexual activity by your partner/ex-partner?
Yes _____ No _____

Have you ever been physically hurt by your partner/ex-partner? Yes _____ No _____

Family History of Cancer

Has anyone in your family ever been diagnosed with cancer? Yes ______ No ______

If yes, please describe the cancer history below. ***Please specify if a relative such as a grandparent, cousin, or aunt/uncle is on the maternal (mother's) side or paternal (father's) side.*** *If you don't know the age at which a relative's cancer was diagnosed, but know an approximate age ("40's", "70's"), please provide that.*

Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __
Name/Relationship to you	*Type of cancer*	*Age at diagnosis*	*Please check*
			Living __ Deceased __

If you need more space, please use another sheet or the back of this sheet.

Please list a friend or relative ***not living with you*** who will always know how to reach you:

Name: _____

Relationship: _____

Address: _____

_____

Preferred contact number (with area code): _____