CAPITAL SURGEONS GROUP

WOMEN'S HEALTH INFORMATION

Patient Name:_____Date of Birth:_____Age:_____Today's Date:_____

Age of 1st Period:_____How many children have you delivered?_____ Age at 1st birth:_____

Is there a possibility that you are pregnant now? Yes or No **Are you Post Menopausal?** Yes or No

Have you ever used Hormone Replacement Therapy? Yes or No
If yes, for how long?_____

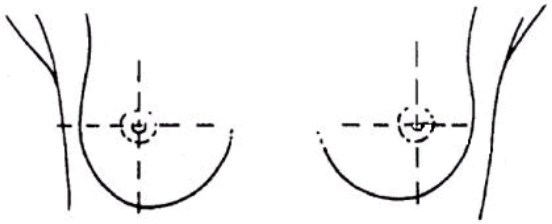
Please mark below if there is **a personal or family history** of any of the following cancers. If yes, then **indicate family relationship** AND **age at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

			You	Siblings/ Children	Mother's Side	Father's Side
Y	N	***Example*: Breast Cancer**		***Sister at 36***	***Aunt at 44***	
Y	N	Breast Cancer				
Y	N	Ovarian Cancer				
Y	N	Breast Cancer in both breast OR multiple primary breast cancers				
Y	N	Male Breast Cancer				
Y	N	Ashkenazi Jewish Ancestry				
Y	N	Pancreatic Cancer				
Y	N	Prostate Cancer				
Y	N	Uterine (Endometrial) Cancer				
Y	N	Colon Cancer				
Y	N	Stomach, Kidney/Urinary Tract, Brain, Small Bowel Cancer, Biliary Tract OR Intestinal Cancers				
Y	N	Melanoma				

Has anyone in your family had genetic testing for a hereditary cancer syndrome? Yes or No

Have you ever had any previous breast biopsies? Yes or No

Please mark the area of concern in the diagram to the side:



Right Breast Left Breast

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Patient is a candidate for testing Yes or No **If YES** Accepted or Declined