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FOR OFFICE USE ONLY: UCMR#: _____ CRC#: _____ - _____ - _____ Date Completed: _____ Date Entered: _____

UNIVERSITY OF CHICAGO CANCER RISK CLINIC NEW PATIENT RISK ASSESSMENT FORM

MEDICAL RECORDS RELEASE FORM

First Name: _____ Last Name: _____
Date of Birth: _____ Maiden Name: _____

I permit the Cancer Risk Clinic at the University of Chicago to contact other medical institutions where I have had my medical care and to obtain my medical records and treatment information from attending physicians and hospitals in order to more accurately assess my familial cancer risk status. This request includes:

Procedure reports	Pathology reports	Radiology reports
Operative reports	Chemotherapy records	Tumor blocks/slides

This signed permission form and attached risk assessment questionnaire are confidential and shall remain in the Cancer Risk Clinic chart. This information will not be part of my medical record chart. This and any other information I share with the Cancer Risk Clinic will only be released to other individuals if I sign a release form designating individuals to whom to release such information. A duplicate copy of this form is as valid as the original.

If through participation in the Cancer Risk Clinic, research leads to information about my personal risk of cancer, I request that this information be communicated to me:

____ Yes, I wish to be given this information.
____ No, I do not want to be given this information.

In the event that I am deceased when this information becomes available, it can be made available to the following individual(s) if they contact the Cancer Risk Clinic:

_____ <i>Name</i>	_____ <i>Relationship to me</i>
_____ <i>Name</i>	_____ <i>Relationship to me</i>
_____ <i>Name</i>	_____ <i>Relationship to me</i>

Signature: _____

Date: _____

Version Date: 06/12/2008

NEW PATIENT RISK ASSESSMENT QUESTIONNAIRE

Please complete all questions in the gender-designated sections below.

MENSTRUAL PERIOD HISTORY (FEMALE PATIENTS ONLY)

- 1) How old were you the first time you had a menstrual period? ____
- 2) Are you still having menstrual periods? Yes No
- 3) How long ago was your most recent menstrual period?
 Less than 1 month ago 7 to 11 months ago
 1 to 6 months ago 1 year ago or longer
- 4) If you have not had your period in more than 1 year, how old were you the last time you had your period before it stopped? ____
- 5) Why did your periods stop?
 Natural menopause, change of life
 Surgery to remove ovaries or uterus
 Chemotherapy or other medical treatment

PREGNANCY HISTORY (FEMALE PATIENTS ONLY)

- 6) Have you ever been pregnant? Yes No
- 7) How many times have you been pregnant? ____
- 8) How many times have you given birth to a live baby? ____
- 9) How old were you the first time you gave birth to a live baby? ____
- 10) How old were you the last time you gave birth to a live baby? ____

HISTORY OF HORMONE USE (FEMALE PATIENTS ONLY)

- 11) Have you ever taken birth control hormones (i.e. pill, patch, injection)? Yes No
- 12) Are you currently taking birth control hormones? Yes No
- 13) In total, how many years have you taken birth control hormones? ____
- 14) Have you ever taken medication to *increase* your chance of becoming pregnant?
 Yes No
- 15) In total, how many months did you take medication to try to become pregnant? ____
- 16) Have you ever taken Hormone Replacement Therapy (HRT)? Yes No
If so, how long were you taking HRT? _____
- 17) Have you ever taken Tamoxifen? Yes No
If yes, please circle one: for Treatment of cancer or DCIS / for Prevention of cancer
How long were you taking Tamoxifen? _____

BREAST CANCER SCREENING (FEMALE PATIENTS ONLY)

- 18) Do you examine your own breasts for lumps? Yes No

- 19) Have you ever detected a lump? Yes No
- 20) Have you ever had a mammogram of your breasts? Yes No
- 21) How old were you the first time you had a mammogram? ____ ____
- 22) How often do you have a mammogram?
- Once every ____ years
 - Once each year
 - More than once a year
- 23) A breast biopsy is a procedure in which a sample of your breast tissue is removed and examined for cancer. How many breast biopsies have you had in your lifetime? ____ ____
- 24) Have you ever been diagnosed with any of the following breast conditions? If so, mark each condition you have had and indicate your age at the time of diagnosis:
- ADH (atypical ductal hyperplasia) Age: ____ ____
 - ALH (atypical lobular hyperplasia) Age: ____ ____
 - LCIS (lobular carcinoma in situ) Age: ____ ____
- 25) Have you ever been diagnosed with breast cancer? Yes No
- 26) At what age were you first diagnosed with breast cancer? ____ ____
- 27) If you have been diagnosed with breast cancer, was it in one or both breasts?
- One Both

OVARIAN CANCER SCREENING (FEMALE PATIENTS ONLY)

- 28) How often do you have pelvic exams?
- Never
 - Every 6 months
 - Every year
 - Every 2 years
 - Sporadically
- 29) How often do you have transvaginal ultrasound exams?
- Never
 - Every 6 months
 - Every year
 - Every 2 years
 - Sporadically
- 30) How often do you have CA-125 blood tests?
- Never
 - Every 6 months
 - Every year
 - Every 2 years
 - Sporadically

CERVICAL CANCER SCREENING (FEMALE PATIENTS ONLY)

31) How often do you have Pap tests?

- Never
- Every year
- Every 2-3 years
- Every 10 years
- More than every 10 years
- Sporadically

32) How often do you have HPV tests?

- Never
- Every year
- Every 2-3 years
- Every 10 years
- More than every 10 years
- Sporadically

SURGICAL HISTORY (FEMALE PATIENTS ONLY)

33) Have you had any of the following surgeries or procedures?

- | | | | |
|---|-----------------------------|--|---------------------------------------|
| <input type="checkbox"/> Hysterectomy (uterus removed) | <input type="checkbox"/> No | <input type="checkbox"/> Yes, at age _____ | |
| <input type="checkbox"/> Oophorectomy (ovaries removed) | <input type="checkbox"/> No | <input type="checkbox"/> Yes, at age _____ | <input type="checkbox"/> both ovaries |
| <input type="checkbox"/> Tubal Ligation (tubes tied) | <input type="checkbox"/> No | <input type="checkbox"/> Yes, at age _____ | |

PROSTATE CANCER SCREENING (MALE PATIENTS ONLY)

- | | | |
|--|------------------------------|-----------------------------|
| 34) Have you ever had a PSA (prostate specific antigen) test? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 35) If so, has the result of your PSA test(s) ever been elevated? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36) Have you ever had a digital rectal exam of your prostate? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 37) If so, has your digital rectal exam result ever been abnormal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

COLORECTAL CANCER SCREENING (ALL PATIENTS)

- | | | |
|--|------------------------------|-----------------------------|
| 38) Has your colon ever been examined by colonoscopy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 39) Has your colon ever been examined by sigmoidoscopy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 40) How many polyps were found? | | |
| <input type="checkbox"/> None | | |
| <input type="checkbox"/> One | | |
| <input type="checkbox"/> Multiple, less than 100 (Specify #: ____) | | |
| <input type="checkbox"/> Multiple, more than 100 (Specify #: ____) | | |

41) Have you ever been diagnosed with any of the following colon conditions? If so, mark each condition you have had and indicate your age at the time of diagnosis:

- Colon or rectal cancer Age: ____ ____
- Crohn's Disease Age: ____ ____
- Colitis Age: ____ ____
- Diverticulitis Age: ____ ____
- IBS (Irritable Bowel Syndrome) Age: ____ ____
- FAP (Familial Adenomatous Polyposis) Age: ____ ____
- HNPCC (Hereditary Non-polyposis Colon Cancer) Age: ____ ____
- Adenoma Age: ____ ____
- Other polyps Age: ____ ____

SKIN CANCER SCREENING (ALL PATIENTS)

- 42) Do you have more than 35 moles on your body? Yes No
- 43) Do you have any moles that are larger than a pencil eraser (5 mm)? Yes No
- 44) Have you ever had a mole removed? Yes No
- 45) If so, did the pathology reveal skin cancer? Yes No
- 46) Do you use sunscreen on a daily basis? Yes No
- 47) Have you ever used a tanning bed? Yes No

HISTORY OF ALCOHOL CONSUMPTION (ALL PATIENTS)

- 48) Have you ever consumed any alcoholic beverages, such as beer, wine, or liquor at least once a week for 6 months or longer? Yes No
- 49) At what age did you first start consuming alcoholic beverages at least once a week for 6 months or longer? ____ ____
- 50) Are you currently consuming alcoholic beverages at least once a week? Yes No
- 51) For how many years in total have you consumed alcoholic beverages at least once a week for 6 months or longer? ____ ____
- 52) When you consumed alcoholic beverages at least once a week, how many of the following types of drinks did you typically consume in a week?
____ ____ 12 oz beers ____ ____ medium glasses of wine ____ ____ shots of liquor

HISTORY OF TOBACCO USE (ALL PATIENTS)

- 53) Have you ever smoked at least 1 cigarette, cigar, or other tobacco product each day for 3 months or longer? Yes No
- 54) At what age did you start smoking at least once a day for 3 months or longer? ____ ____
- 55) Are you currently smoking at least once a day? ____ ____
- 56) If you are not currently smoking at least once a day, at what age did you last smoke? ____ ____
- 57) For how many years in total have you smoked at least once a day? ____ ____
- 58) When you smoked at least once a day, how many cigarettes or other tobacco products did you typically smoke each day? ____ ____

Cancer History of Family Members

Please complete the following cancer history for your family. If you do not know exact ages, please estimate. If you have additional family members with cancer, please add them to the bottom of this sheet.

	Current Age	Age at Death	First Cancer Type	Age at First Cancer Diagnosis	Second Cancer Type	Age at Second Cancer Diagnosis	Age Ovaries Removed (if ever)
Yourself <input type="checkbox"/> Male <input type="checkbox"/> Female							
Your siblings (Please circle sister or brother)							
Sister Brother							
Sister Brother							
Sister Brother							
Sister Brother							
Your children (Please circle daughter or son)							
Daughter Son							
Daughter Son							
Daughter Son							
Daughter Son							
Your father's family (Please circle aunt or uncle)							
Father							
Paternal Grandfather							
Paternal Grandmother							
Aunt Uncle							
Aunt Uncle							
Aunt Uncle							
Aunt Uncle							
Your mother's family (Please circle aunt or uncle)							
Mother							
Maternal Grandfather							
Maternal Grandmother							
Aunt Uncle							
Aunt Uncle							
Aunt Uncle							
Aunt Uncle							