Established Patient Interval History Update Form

Patient Name:_____ Emergency Contact:_____

Current Tobacco Use: Yes□ No
How much alcohol do you drink? □ P/day_____ P/week_____ P/month_____
Do you exercise? □ Yes □No What type of exercise?_____ Times/week:_____
Marital Status:(circle one) Single Married Divorced Widowed

Who is your Primary Care Physician?_____
Other treating Physicians: _____ For:_____
_____ For:_____

Date last menstrual period started_____ or Menopausal Since:_____
Do you experience cramps? □ None □Mild □Moderate □ Severe (circle one)
Does your menstrual cycle occur once a month? Yes No
How many days do you normally bleed _____ Mild Moderate Heavy (circle one)
How often does your menstrual cycle start? Every_____ Days or Weeks (circle one)

Are you trying to conceive? Yes No
Are you using contraception? Yes No
What method (s) of contraception are you currently using? Please circle all that apply.

Abstinence	Withdrawal	Condoms	Birth Control Pill	Patch
Rhythm	IUD	Tubal Ligation	Patch	Essure
Injectable	Vasectomy	Nuva Ring	Nexplanon	

Date of last Mammogram _____
Have you had a colonoscopy or cologuard since your last visit? □Yes □No Date:_____
Have you had a bone density since your last visit? □Yes □No Date:_____

Do you have any **NEW** medical issues since your last visit? Yes No Please check all that apply:

( ) High Blood Pressure	( ) High Cholesterol	( )Thyroid Disease
( ) Heart Disease	( ) Stroke	( ) Arthritis
( ) Heart Attack	( ) Depression / Anxiety	
( ) Psychiatric Disorder	( ) Diabetes	

List any other medical issues since your last visit _____Date:_____

Have you had any surgeries or hospitalizations since your last visit? □Yes □No
Surgery/Hospitalization:_____ Date:_____
Surgery/Hospitalization:_____ Date:_____

Have you had a tetanus or TDAP booster in the last 10 yrs? Yes No - Do you want one today? Yes No

Please list all current **medications & dosages** (Prescription, Non-Prescription, Vitamins, or Supplements including calcium or herbal supplements) If you need additional space, please use the back of this form and check here ☐
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Medication:_____ Dosage:_____
Have you developed any allergies to medications, food, or latex since your last visit? Yes No
If Yes, Please explain _____

☐ **If there are no changes since your last visit, check this box and stop here**.

Patient Name:_____

FAMILY MEDICAL HISTORY - Please list any changes to your family medical history that you are aware of: Example diabetes, heart disease, cancer

Illness	Relative	Maternal Or Paternal side of family	Age at Diagnosis	Comments	Are they still living? Yes or No

Family History Questionnaire for **Common Hereditary Cancer Syndromes**

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.

Have you ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If Yes, the results were:_____
Has any member of your family ever had genetic testing for Hereditary Risk of Cancer? Yes or No
If yes, the results were:_____
If you answered yes to either questions above, please obtain copy of relatives test results.

Breast and Ovarian Cancer	You	Age at diagnosis	Siblings/ children	Age at diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Breast Cancer (male or female)								
Ovarian Cancer								
Breast cancer in both breasts OR Multiple primary breast cancers								
Male Breast Cancer								
Pancreatic Cancer								
Prostate Cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Colon and Uterine Cancer	You	Age at diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side (relation)	Age at diagnosis	Father's Side (relation)	Age at diagnosis
Uterine (endometrial) Cancer								
Colorectal Cancer								
10 or more cumulative colon polyps								