



A New Beginning – Obstetrics and Gynecology
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Obstetrics and Gynecology History

NAME: _____ **TODAY'S DATE:** _____ **BIRTHDATE:** _____

Marital Status Single Married Divorced Widowed Partner Separated

Occupation _____

Last Pap Smear _____

History of Abnormal Pap Smear? _____ **If yes, what was result** _____

Last Mammogram _____ **Do you perform monthly Breast exams?** Yes No

Last Bone Density _____

Last Colonoscopy _____

Last Cholesterol Test _____

Still having periods? Yes No **If no, age menopause began** _____

First day of last menstrual period _____ **Age of first period?** _____

Periods come every _____ **days** **Periods last how many days?** _____

Periods are Light Moderate Heavy Painful Irregular

Do you bleed between periods? Yes No

Are you Sexually Active? Yes No **Do you bleed after sex?** Yes No

Currently on Birth Control? Yes No

If yes, what type? _____ **If IUD or Nexplanon, what is insertion date?** _____

History of chronic yeast or bacterial infections? If Yes, which _____

History of STD? Chlamydia Gonorrhea Trichomoniasis Herpes Genital Warts HIV Syphilis

History of PID? Yes No

Exposure to Diethylstilbestrol (DES)? Yes No

Human Papillomavirus (HPV) vaccines? Yes No

Have you ever been Pregnant? Yes No

Number of pregnancies _____ **Number of Live Births** _____ **Number of Living Children** _____

Number of Miscarriages _____ **Number of Elective Terminations** _____

Number of C-Section Deliveries _____ **Number of Vaginal Births** _____

Number of Premature Births <37 wks _____

Continued... 

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____
Date of Birth: _____

Physician Name: _____
Today's Date: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives** Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for hereditary cancer (HBOC/BRACAnalysis or Lynch/COLARIS)? YES NO
Have you ever been diagnosed with cancer? What site: _____ What age: _____

COLON AND UTERINE CANCER (COLARIS)			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	THREE (3) relatives on the same side of the family with Uterine (Endometrial) and/or Colorectal cancer at any age				
Y	N	TWO (2) relatives on the same side of the family with Uterine (Endometrial) and/or Colorectal cancer under age 50				
Y	N	ONE (1) Uterine (Endometrial) and/or Colorectal cancer under age 50 in self				
Y	N	A family member with a known Lynch Syndrome mutation				

BREAST AND OVARIAN CANCER (BRACAnalysis)			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	ONE (1) Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	N	ONE (1) Ovarian cancer at any age (in self, first or second degree family members)				
Y	N	TWO (2) relatives on the same side of the family with breast cancer, one of whom was diagnosed at age 50 or younger (in self, first or second degree)				
Y	N	THREE (3) relatives on the same side of the family with breast and/or ovarian cancer at any age				
Y	N	ONE (1) Triple negative breast cancer age 60 or younger - receptor status negative for ER, PR and HER2 (in self, 1 st or 2 nd degree family members)				
Y	N	ONE (1) Male breast cancer at any age (in self, first or second degree family members)				
Y	N	ONE (1) Breast or ovarian cancer in Ashkenazi Jewish family members				
Y	N	ONE (1) Pancreatic cancer with 2 or more breast and/or ovarian cancers on the same side of the family				
Y	N	A family member with a known BRCA mutation				

Are you of Jewish descent? YES NO

Is there any other cancer in you or any family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer:

Patient's signature: _____

Today's Date: _____

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Patient does not meet criteria for further risk assessment and/or genetic testing

Patient is appropriate for further risk assessment and/or genetic testing

Information given to patient to review

Follow-up appointment scheduled on _____

Patient offered genetic testing: Accepted OR Declined HCP Signature: _____

