Name: ______________________

DOB: _____________ **Age:** ______

Today's Date: _____________

Well Adult Exam – Female

Gyn History
Date of last menstrual period: ______________
Sexually Active: □Yes □No
Month/Year of last Pap smear: ____________
History of abnormal Pap smear: □Yes □No
History of STD: □Yes □No
Birth Control Method:
□ Birth Control Pills □ IUD: Brand ____________ Year placed _________
□ Condoms □ Depo Provera □ Vasectomy
□ Tubal Ligation □ None □ Other _____________

OB History
Total # of pregnancies: ________
History of c-section: □Yes □No
History of miscarriage: □Yes □No
History of hysterectomy: □Yes □No

Preventive History
Family History of Breast Cancer: □Yes □No
Family History of Ovarian Cancer: □Yes □No
Family History of Colon Cancer: □Yes □No
Have you had genetic testing for cancer: □Yes □No
Year of last Colonoscopy (if 45 years of age or risk factors): __________
Year of last Mammogram (40+ or risk factors): __________
Year of last Bone Density Scan (65+ or risk factors): __________
Year of last Tetanus booster: __________
Annual Flu Vaccine: □Yes □No
COVID-19 Vaccine: □Yes □No
Gardasil Vaccine (11-45 years old): □Yes □No
Pneumonia Vaccine (50+ or risk factors): □Yes □No
Shingles Vaccine (50+): □Yes □No
Daily multivitamin: □Yes □No
Vitamin D3 Supplement 2000IU: □Yes □No
Have you ever smoked or used chewing Tobacco : □Yes □No
If **yes**, how many years have you/did you smoke? _________
If **yes**, how many packs per day? _________
If **yes** and you quit, at what age did you quit? _______
If you are over 50 and have a 20-pack year history of smoking, when was your last CT lung cancer screening: Year _______
Do you regularly consume more than 6 alcohol drinks per week? □Yes □No
Please provide the following if you are due for your mammogram this year:
Bra size __________
Implants: □Yes □No

Please see next page

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things:

   □ Not at all
   □ Several days
   □ More than half the days
   □ Nearly every day

2. Feeling down, depressed, or hopeless?

   □ Not at all
   □ Several days
   □ More than half the days
   □ Nearly every day

Please see next page

Family history questionnaire

MyRisk™
Hereditary Cancer Test

Personal information

Patient name	Date of birth	Healthcare provider	Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces** and **nephews** on both sides of the family. For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of:	Yes(Y)/No(N)	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have family history of:	Yes(Y)/No(N)	Maternal(M)/ Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Y ☐ N	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N	☐ M ☐ P		
Ovarian cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Male breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Colon cancer at 49 or younger (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Uterine cancer at 49 or younger (1st-degree relative)	☐ Y ☐ N	☐ M ☐ P		
Three colon and/or uterine cancers on the same side of the family at any age	☐ Y ☐ N	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?		What gene?	Result?

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature	Date
Healthcare provider signature	Date

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk™ ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk™

☐ COLARIS®PLUS with MyRisk™ ☐ COLARIS AP®PLUS with MyRisk™ ☐ Single Site Testing ☐ MyRisk™ Update Test

☐ Other: ____________________

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: ____________