Hackensack Meridian *Health*

☐ JSUMC
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Neptune, NJ 07754

☐ OMC
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Brick, NJ 08724

☐ RMC
1 Riverview Plaza
Red Bank, NJ 07701

Medical History Questionnaire

Name:_____ _____ _____ _____
(last) (maiden) (first) (middle)

What is your race/ethnic background? If you are multiracial, check all that apply:

_____ Caucasian _____ Black _____ Hispanic _____ Asian _____ Native American

Other (specify)_____

Are you of Eastern European (Ashkenazi) Jewish descent? Yes_____ No_____

Have you ever had a cancer diagnosis? Yes_____ No_____
If yes, what type(s) of cancer? _____
How old were you when your cancer was diagnosed? _____

If you have been diagnosed with cancer, please bring a copy of your medical records to your appointment.

Gynecologic/Reproductive History (for women only):

- How old were you when your menstrual periods began? _____
- Are you still having menstrual periods? Yes_____ No_____
  If not, how old were you when your periods stopped? _____
- When was your last gynecological exam? _____
- Have you ever taken oral contraceptives (birth control pills)? Yes_____ No_____
- Have you ever been on hormone replacement therapy? Yes_____ No_____
- Have you had your uterus surgically removed? Yes_____ No_____

- Have you had your ovaries surgically removed? Yes_____ No_____
  One ovary____ Both _____
- How many times have you been pregnant? _____
- How many living children do you have? _____
- If you have ever been pregnant, how old were you at the time of your first pregnancy? _____
- How old were you when you had your first liveborn child? _____
- Have you ever used medication to help you get pregnant? Yes_____ No_____

Breast Health:

- Do you have a history of breast problems (besides cancer)? Yes_____ No_____
  If yes, what type? (fibrocystic changes, benign tumors?) _____
- Have you ever had a breast biopsy? Yes_____ No_____
  If yes, how many have you had? _____
  What were the results? _____
- When was your last mammogram? _____
- When was your last clinical breast exam? _____
- Do you perform breast self-exams? Yes_____ No_____
  How often? _____

If you have had an abnormal breast biopsy, mammogram, etc., please bring a copy of the report to your appointment.

Colon Health:

- Have you ever had polyps in your colon or rectum? Yes_____ No_____
  How old were you when you were first found to have them? _____
  How many polyps did you have at that time? _____ Unsure_____
  How many polyps (total) have you ever had? 1 2 3 4 5 6-15 16-50 51-100 >100
- Do you have inflammatory bowel disease? Yes_____ No_____
- (Crohn's/Ulcerative colitis)? Yes_____ No_____
  If yes, at what age was it diagnosed? _____
- Have you had a fecal occult blood test within the last year? Yes_____ No_____
- Have you had a flexible sigmoidoscopy within the last 5 years? Yes_____ No_____
- Have you had a colonoscopy within the last 10 years? Yes_____ No_____

If you have had a colon polyp, abnormal colonoscopy, etc., please bring a copy of the report to your appointment.

Lifestyle History:

- Have you ever smoked cigarettes? Yes_____ No_____
- Do you currently smoke? Yes_____ No_____
  How many packs per day do you smoke? _____
- Do you drink alcohol? Yes_____ No_____
  Approximately how many drinks per week? _____

Are there any environmental exposures you are aware of that might increase your cancer risks, such as asbestos, toxic chemicals, etc?

Please describe any ongoing health problems we should know about (heart disease, multiple sclerosis, etc.).

What are the primary concerns that you would like addressed during your appointment?