GREENVILLE HEALTH SYSTEM
Cancer Institute

PERSONAL MEDICAL HISTORY

Preferred First Name	Last Name	Age at Appointment Date
Race/Ethnicity		
	Are you Hispanic? ☐ **Yes** ☐ **No**	Do you have Ashkenazi Jewish background? ☐ **Yes** ☐ **No**
Height	**Weight**	

1. Do you have cancer now or have you ever been diagnosed in the past?		☐ Yes ☐ No
If yes, please list when it occurred, the type(s) of cancer (i.e. left breast, colon), and the treatments you had or are scheduled for (i.e. mastectomy, chemotherapy).		
Year/Age	**Type of cancer**	**Treatments**

2. Have you ever had a colonoscopy, sigmoidoscopy or EGD (upper endoscopy)?		☐ Yes ☐ No
If yes, please list the year or your age at the time of each procedure and the result.		
Year/Age	**Procedure type**	**Number of polyps removed**

3. Have you ever had skin lesions or skin cancer removed?		☐ Yes ☐ No
If yes, please list the type and location of lesion and when it was removed.		
Year/Age	**Location on body**	**Type of lesion**

4. Have you ever had a stem cell transplant, bone marrow transplant or blood transfusion?
☐ **Yes** ☐ **No**
5. Please list any other major health conditions and/or surgeries you have had below:

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FOR WOMEN ONLY

1. How old were you when you had your first period?		
2. Are you still having periods?		☐ **Yes** ☐ **No, age ended: ______**
3. Did you have surgery to remove your uterus and/or ovaries?		☐ **Yes** ☐ **No**
If yes, please list the dates or your age when you had the surgeries:		
	Reason for Surgery (i.e. prolapse, cysts, abnormal bleeding)	**Date/Age**
Uterus		
Left ovary		
Right ovary		
3. Have you ever been pregnant?		☐ **Yes** ☐ **No**
If yes, please answer the following questions:		
How many times have you been pregnant?		
How many living children did you deliver?		
How old were you when you delivered your first live born child?		
4. Have you ever taken birth control pills for 3 to 5 years continuously?		☐ **Yes** ☐ **No** ☐ **Never used**
5. Have you ever taken hormone therapy to treat menopausal symptoms replacement therapy?		☐ **Yes** ☐ **No**
If yes, please list the types of hormone therapy you used and how long you took them.		
Hormone Replacement Medication(s)		**Years used**
6. Have you ever taken a pill to prevent breast cancer (i.e. Tamoxifen, Evista)?		☐ **Yes** ☐ **No**
7. Have you ever taken Evista (Raloxifene) to treat osteopenia or osteoporosis?		☐ **Yes** ☐ **No**
8. How many breast biopsies have you had?		**# left breast: _______** **# right breast: _______**
9. Did you ever have a breast biopsy that showed atypical hyperplasia or ADH or LCIS or was called "pre-cancerous"?		☐ **Yes** ☐ **No** ☐ **Not sure**