

Name: _____

Family History and Genetics

	Current Age & Physical Ailments or Cause of Death	CANCER HISTORY				GENETIC TESTING	
		Breast Age at Diagnosis	Ovarian Age at Diagnosis	Colon Age at Diagnosis	Other Age at Diagnosis	Yes: Result	No
IMMEDIATE FAMILY							
Patient's Siblings							
Sister	Brother						
Sister	Brother						
Sister	Brother						
Sister	Brother						
Patient's Children							
Daughter	Son						
Daughter	Son						
Daughter	Son						
Daughter	Son						
MATERNAL FAMILY							
Mother							
Grandmother							
Grandfather							
Aunt	Uncle						
Aunt	Uncle						
Aunt	Uncle						
PATERNAL FAMILY							
Father							
Grandmother							
Grandfather							
Aunt	Uncle						
Aunt	Uncle						
Aunt	Uncle						

Distress Scale

On a scale from 1-10 please indicate how you are currently feeling by circling the number that corresponds to your distress level. A number 1 indicates no distress; a number 10 indicates extreme distress.

No Distress

Extreme Distress

				<u>Practical Concerns</u>								
Housing	1	2	3	4	5	6	7	8	9	10		
Insurance	1	2	3	4	5	6	7	8	9	10		
Work/School	1	2	3	4	5	6	7	8	9	10		
Transportation	1	2	3	4	5	6	7	8	9	10		
Child Care	1	2	3	4	5	6	7	8	9	10		
					<u>Family Concerns</u>							
Partner/Spouse	1	2	3	4	5	6	7	8	9	10		
Children	1	2	3	4	5	6	7	8	9	10		
Parents	1	2	3	4	5	6	7	8	9	10		
					<u>Emotional Concerns</u>							
Worry	1	2	3	4	5	6	7	8	9	10		
Sadness	1	2	3	4	5	6	7	8	9	10		
Depression	1	2	3	4	5	6	7	8	9	10		
Nervousness	1	2	3	4	5	6	7	8	9	10		
					<u>Spiritual/Religious Concerns</u>							
Relating to God	1	2	3	4	5	6	7	8	9	10		
Loss of Faith	1	2	3	4	5	6	7	8	9	10		
Other Concerns	1	2	3	4	5	6	7	8	9	10		

*This tool is gratefully used with the permission of Jimmie Holland, MD, Memorial Sloan Kettering Cancer Center

Name: _____

Symptoms: (Check those that apply)

General Symptoms:

- Change in appetite
- Weight Loss
- Fever
- Chills
- Night Sweats
- Hot Flashes
- Itching

Eyes:

- Glasses or contact lenses

Ears, Nose, Mouth, Throat:

- Hearing Problems
- Nose Bleeds
- Sinus Problems
- Dental Problems
- Sore Throat
- Hoarseness

Musculoskeletal (Bones and Joints)

- Stiffness
- Swelling
- Back Pain: _____

Cardiovascular: (Heart and Circulation)

- Chest Pain
- Irregular Heart Beat
- Difficulty breathing when lying down
- Leg or ankle swelling

Respiratory (Lungs)

- Shortness of Breath
- Wheezing
- Cough
- Sputum or Phlegm Production
- Coughing up Blood

Gastrointestinal: (Stomach and Bowels)

- Swallowing Difficulty
- Heartburn
- Nausea / Vomiting
- Diarrhea/ Constipation
- Rectal Bleeding
- Abdominal Pain

Genitourinary (Kidneys, Bladder)

- Urgency
- Frequency
- Up at Night to Urinate
- Burning
- Bleeding
- Leakage

GYN / OB

- Menstruating at age _____
- Date Last Period _____
- # of Births _____
- # of Children _____
- # of Miscarriages _____
- Did You Breast Feed _____
- Hormone Therapy _____
- If yes: How Long _____
- Date Stopped _____

Lymphatic

- Enlarged /Tender lymph nodes

Neuropsychiatry: (Nervous System)

- Trouble Sleeping
- Headache
- Balance Difficulties
- Loss of Consciousness
- Seizures
- Weakness in Arms or Legs
- Numbness in Arms or Legs

Integumentary (Skin or Breasts)

- Skin Problems / rash
- Lump / mass initially detected on _____ by
 - Self exam
 - MD exam
 - Mammogram / US
- Nipple Discharge
- Nipple Retraction
- Breast Redness / Swelling
- Breast Pain