PREVIOUS CANCER TREATMENT

Radiation/X-ray Treatment:
- Body Part:
- Treatment:
- Date:
- Facility:
- Doctor:

Chemotherapy:
- Date of last treatment:
- Drugs:
- Facility:
- Doctor:

GYNECOLOGICAL HISTORY

- Number of Pregnancies
- Date of 1st period
- Date of last mammogram
- Previous breast biopsy
- Number of live births
- Menopause
- Date of Last Pap Smear
- Are you pregnant
- Date of last menstrual cycle
- Type of hormone therapy
- Do you do self breast exam
- Benign breast problems

FAMILY HISTORY

Relation | Age | Medical Problems | If deceased, age and cause of death
---|---|---|---
Father | | | |
Mother | | | |
Brother(s) | | | |
Sister(s) | | | |
Child(ren) | | | |
Other blood relatives with health problems and age at diagnosis:

PERSONAL/SOCIAL HISTORY

- Do you live alone
- If no, with whom do you live
- Are you retired
- If yes, when
- Former occupation
- If no, current occupation
- Do you drink alcohol
- If yes, how much drinks per day/week (circle)
- Do you or did you smoke
- If yes, how much packs per day for years
- Use recreational drugs
- Which
- When
- Been on a special diet
- What
- When
- Are there any religious or spiritual issues, which may have an impact on your care
- If yes, what are they