FINANCIAL RESPONSIBILITY/WAIVER FORM

Patient: _____ Subscriber: _____

Address: _____ Employer: _____

D.O.B.: _____ Spouse: _____

Home Phone: (___) _____ Work Phone: (___) _____

Insurance: _____ No.: _____ Co Pay: _____ Ed: _____

Positive verification of your coverage cannot be made at this time. You will receive services today with the understanding that in the event your coverage is not effective you will be billed and held financially responsible for these services rendered.

I have read the above and understand my possible financial responsibility for services rendered and hereby affix my signature as an acknowledgement of this understanding.

Date: _____ Patient's Signature: _____

Date: _____ Witness Signature: _____

MEDICAL HISTORY REGISTRATION FORM

NAME: _____ **AGE:**_____ **LAST MENSTRUAL PERIOD:** _____
Date: _____

PAST AND CURRENT MEDICAL/SURGICAL HISTORY
Please list all medical problems, past significant illnesses, operations and dates:

_____
_____
_____
_____

SOCIAL HISTORY
Do you smoke? _____ If yes how many cigs or packs/day_____
Do you drink? _____ If yes how much and when _____
Have you currently and/or in the past used any drugs? _____
If yes please list and when last used _____
_____

ALLERGIES _____
Please list allergies to any drugs and/or medications _____

CURRENT DRUGS/MEDICATIONS_____
Please list all medications you are currently taking _____
_____

MENSTRUAL HISTORY
Age of onset _____ how many days apart _____ how many days of bleeding _____
Do you have menstrual cramps? _____ is the bleeding light/medium/or heavy? _____

FAMILY HISTORY
Please check and identify all family members that are affected
Diabetes _____
Cancer _____
(Breast, Ovarian, Colon or other)
High Blood Pressure _____
Heart Disease _____
Genetic Diseases _____
Other _____

OBSTETRICAL HISTORY
Total # of times you have been pregnant _____ # of full-term births _____ # of premature births _____
# of miscarriages and/or abortions _____ # of living children _____ Method of birth control _____
Any complications with pregnancy? _____

Date of last pap smear _____
Any abnormal pap? / What was followup and treatment? _____

Do you have any of the following?
_____ Involuntary loss of urine?
_____ Hot flashes?
_____ Abnormal bleeding?
_____ Severe menstrual cramps?

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer (male or female)								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic or prostate cancer								
Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No								
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Colon/rectal, uterine/endometrial, ovarian, stomach/gastric, kidney/urinary tract, biliary tract, small bowel, pancreas, brain, and sebaceous adenomas								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
_____								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: _____

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY

☐ Patient appropriate for further risk assessment and/or genetic testing
- ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome
- ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes
- ☐ MELARIS® – A test for Hereditary Melanoma

☐ Discussed hereditary cancer risk with patient
☐ Patient offered genetic testing
- ☐ ACCEPTED ☐ DECLINED

☐ Follow up appointment scheduled
Date: _____

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