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Fred Hutch Cancer Center

Breast And Ovarian Cancer Prevention Program Questionnaire

Full Name _____ Date of Birth _____

Today's date _____ What is your preferred pronoun? _____

Referred by: _____

Primary Care Provider: _____

What is the reason for your visit? _____

FOR CLINIC USE ONLY

HT (cm) _____

WT (kg) _____

Questions you would like addressed at this visit: _____

Medical History

How tall are you? _____ How much do you weigh? _____

Check all that apply to your medical history:

☐	High Blood Pressure	☐	Diabetes	☐	Osteoporosis	☐	Uterine Fibroids
☐	Bleeding Problems	☐	History of Clots	☐	Stroke	☐	Thyroid Disease
☐	Heart Disease	☐	Depression or anxiety	☐		☐	
☐	Cancer diagnosis (please specify) _____						

	Yes	No	Comments
Other major medical illnesses?	☐	☐	
Surgeries and dates:			
Any surgical complications?	☐	☐	
Have you had a bone density evaluation (DEXA scan)?	☐	☐	

Living History

	Yes	No	Comments
Are you currently married/partnered?	☐	☐	
Are you planning on having children in the future?	☐	☐	
Do you live alone?	☐	☐	
Are you currently working?	☐	☐	Past/Current Occupation(s) _____
Do you currently smoke?	☐	☐	
Have you ever smoked?	☐	☐	For how many years? _____ On average, how many packs a day? _____
Do you drink alcohol?	☐	☐	On average, how many drinks per week? _____
Do you follow a special diet for medical or personal reasons?	☐	☐	Please describe: _____
Do you currently suffer from an eating disorder? Have you ever suffered from an eating disorder in the past?	☐	☐	
Do you exercise?	☐	☐	On average, how many hours per week do you regularly exercise? _____ What type of exercise does this primarily include? _____
How many hours of sleep do you get each night, on average?			_____
Do you now, or have you ever, had sex with: ☐ Biological Male ☐ Biological Female ☐ Both ☐ None			

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Breast And Ovarian Cancer Prevention Program Questionnaire

Review of Systems

	Yes	No	Comments
General - weight gain	☐	☐	
Weight loss	☐	☐	
Fatigue	☐	☐	
Insomnia	☐	☐	
Fever/chills	☐	☐	
Eyes - glasses/contacts	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Ear/Nose/Throat - sinus trouble	☐	☐	
Hearing loss	☐	☐	
Heart - chest pain	☐	☐	
High blood pressure	☐	☐	
Coronary artery disease	☐	☐	
Irregular heart beat	☐	☐	
Lungs - shortness of breath	☐	☐	
Asthma	☐	☐	
Lung disease	☐	☐	
Stomach - heartburn	☐	☐	
Nausea	☐	☐	
Diarrhea	☐	☐	
Hepatitis	☐	☐	
Muscle/Bones - joint pain	☐	☐	
Muscle pain	☐	☐	
Arthritis	☐	☐	
Fractures	☐	☐	
Sprains	☐	☐	
Urinary Track - painful urination	☐	☐	
Kidney stones	☐	☐	
Arthritis	☐	☐	
Skin - masses	☐	☐	
Blisters	☐	☐	
Dermatitis	☐	☐	
Eczema	☐	☐	
Neurologic - seizures	☐	☐	
Headaches	☐	☐	
Numbness/tingling	☐	☐	
Mental Health - depression	☐	☐	
Anxiety	☐	☐	
Endocrine - frequent urination	☐	☐	
Excessive thirst	☐	☐	
Diabetes	☐	☐	
Hypothyroid	☐	☐	
Hematologic - anemia	☐	☐	
Bleeding/clotting problems	☐	☐	
Swollen lymph nodes	☐	☐	
Allergic/immunologic - HIV/AIDS	☐	☐	
Hay fever	☐	☐	
Lupus	☐	☐	

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(WOMEN ONLY) Gynecologic History

	Yes	No	Comments
At what age did you begin to menstruate?			
Do you still menstruate?	☐	☐	Date of last period:
Are your periods regular?	☐	☐	
Reason for not menstruating:			
• Natural menopause	☐	☐	
• Hysterectomy	☐	☐	Reason and date: _____ How many ovaries removed: _____
• Breastfeeding	☐	☐	
• Other	☐	☐	Please explain:
Have you ever taken hormone replacement therapy (HRT)?	☐	☐	At what age did you start? _____
Are you *currently* taking HRT?	☐	☐	At what age did you stop? _____ Longest duration of HRT use: _____
HRT includes postmenopausal estrogen or progesterone. Please list which drug(s) you have taken:			
Have you ever taken birth control pills (BCP)?	☐	☐	At what age did you start?
Are you *currently* taking BCP?	☐	☐	At what age did you stop? _____ Total years of use: _____
What is your current method of birth control?			
Date of your last pap smear			
Was it normal or abnormal?			
Have you ever had an abnormal pap test?	☐	☐	When?
Have you ever had a pelvic ultrasound?	☐	☐	When?
Have you ever had ovarian cancer?	☐	☐	When? _____ What treatment did you have? _____

Reproductive History

Number of pregnancies (0 = None) _____	Age at first full-term pregnancy _____
Number of miscarriages (0 = None) _____	Number of stillbirths (0 = None) _____
Number of children (0 = None) _____	Birthdates: _____
Number of vaginal deliveries _____	Number of c/sections _____

	Yes	No	Comments
Did you breast feed?	☐	☐	How many total months of breast feeding? _____
Do you have pain with intercourse?	☐	☐	
Do you have pelvic pain?	☐	☐	
Do you have a history of infertility?	☐	☐	
Any gynecologic problems or surgeries not already described?	☐	☐	Please explain:

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Breast History

Yes	No		Right	Left	Past	Current
☐	☐	Benign Mass/Lump(s)	☐	☐	☐	☐
☐	☐	Nipple Discharge	☐	☐	☐	☐
☐	☐	Breast Pain	☐	☐	☐	☐
☐	☐	Previous Breast Biopsy	☐	☐	Date _____	How Many _____
☐	☐	Other Breast Surgery	☐	☐	Date _____	Type of Surgery _____
☐	☐	Do you do breast self-exams? How often? _____				
☐	☐	How often does a doctor do a breast exam? _____			When was your last one? _____	
☐	☐	Previous Mammogram(s) Date of most recent _____			How often do you have them? _____	
☐	☐	Have you had breast cancer? Date of diagnosis _____				

1. How would you rate your general health today? (select one)

◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor

2. For each statement below, select the answer that shows how much you agree.

	Not at all	A little	Somewhat	Quite a bit	A lot
a. Fears of developing cancer have affected my relationships with others.	◯	◯	◯	◯	◯
b. Thoughts of cancer have affected my ability to sleep.	◯	◯	◯	◯	◯
c. Thoughts of cancer have affected my work.	◯	◯	◯	◯	◯
d. Concerns about cancer have affected my ability to have fun.	◯	◯	◯	◯	◯
e. Fears of cancer have affected my ability to feel sexually attracted.	◯	◯	◯	◯	◯
f. Worries about cancer have affected my ability to meet the needs of my family.	◯	◯	◯	◯	◯
g. Cancer concerns have affected my ability to concentrate.	◯	◯	◯	◯	◯

3. Please select one answer for each question below. During the **LAST MONTH**, how often ...

	Not at all or rarely	Sometimes	Often	Almost all the time
a... have you thought about your own chances of developing cancer?	◯	◯	◯	◯
b... have you worried about your own chances of developing cancer?	◯	◯	◯	◯
c... have thoughts about your chances of getting cancer affected your mood?	◯	◯	◯	◯
d... have thoughts about your chances of getting cancer affected your ability to perform your daily activities?	◯	◯	◯	◯

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Breast And Ovarian Cancer Prevention Program Questionnaire

1. **Please select one answer for each question below.** Over the **LAST TWO WEEKS**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○
c. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
d. Feeling tired or having little energy	○	○	○	○
e. Poor appetite or overeating	○	○	○	○
f. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down	○	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you were moving around a lot more than usual	○	○	○	○

2. **In the LAST MONTH, have you had an anxiety attack – suddenly feeling fear or panic?**
☐ Yes ☐ No

3. If you answered **YES** to **Question 5**, please select yes or no for each of the next questions. If you answered **NO**, please **skip to Question 7.**

	YES	NO
a. Has this ever happened before?	☐	☐
b. Do some of the attacks come suddenly out of the blue – that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
c. Do these attacks bother you a lot, or are you worried about having another attack?	☐	☐
d. Were you short of breath?	☐	☐
e. Did you heart race, pound, or skip?	☐	☐
f. Did you have chest pain or pressure?	☐	☐
g. Did you sweat?	☐	☐
h. Did you feel as if you were choking?	☐	☐
i. Did you have hot flashes or chills?	☐	☐
j. Did you have nausea, an upset stomach, or feel like you were going to have diarrhea?	☐	☐
k. Did you feel dizzy, unsteady, or faint?	☐	☐
l. Did you have tingling or numbness in parts of your body?	☐	☐
m. Did you tremble or shake?	☐	☐
n. Were you afraid you were dying?	☐	☐

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Breast And Ovarian Cancer Prevention Program Questionnaire

1. Over the LAST MONTH, how often have you been bothered by these problems? (select one)

	Not at all	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	◯	◯	◯
b. Feeling restless so it is hard to sit still	◯	◯	◯
c. Getting tired very easily	◯	◯	◯
d. Muscle tension, aches, or soreness	◯	◯	◯
e. Trouble falling asleep or staying asleep	◯	◯	◯
f. Trouble concentrating on things, such as reading a book or watching TV	◯	◯	◯
g. Becoming easily annoyed or irritable	◯	◯	◯

2. If you answered "Several days", "More than half the days", "Nearly every day" or "Yes" to any part of questions 4 through 7, how difficult have these problems made it for you to do your work, take care of things, at home, or get along with other people? (select one)

◯ Not difficult at all ◯ Somewhat difficult ◯ Very difficult ◯ Extremely difficult

3. Please answer these two questions about how you rate your cancer risk:

a. I feel like my chance to develop cancer is: (select a number)
(Very Low) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 (Very High)

b. Compared to other people, my chance of getting cancer sometime in my life is: (select one)
◯ Much lower ◯ A little lower ◯ About the same ◯ A little higher ◯ Much higher

4. How much control over your cancer risk do you feel you have? (select one)

◯ Not at all ◯ Slight amount ◯ Moderate amount ◯ Large amount ◯ Total Control

5. How much uncertainty do you currently experience in your life as a result of your cancer risk? (select one)

◯ None ◯ Slight amount ◯ Moderate amount ◯ Large amount ◯ Extremely large amount

6. How effective are you in coping with your cancer risk? (select one)

◯ Not at all ◯ Slightly effective ◯ Moderately effective ◯ Very effective ◯ Extremely effective

7. To what degree does your cancer risk get in the way of your developing life goals? (select one)

◯ None ◯ Slight amount ◯ Moderate amount ◯ Large amount ◯ Extremely large amount

8. Would you be interested in a phone follow-up call from an Fred Hutchinson Cancer Center clinical social worker to discuss methods for reducing distress caused by anxiety and/or depression?

☐ Yes ☐ No

	Yes	No
Do you have any trouble with financial hardship that you would like to discuss?	☐	☐
Are you interested in being on our mailing list for newsletter and research updates?	☐	☐
Can we contact you in the future regarding research studies that you may be eligible for?	☐	☐
If yes, how would you prefer to be contacted (check all that apply)		
☐ Mail _____		
☐ Phone _____		
☐ Email _____		

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Medication List

Clinic Appointment Date: _____ **Time:** _____

Demographic Information (Please print clearly)	
Full Legal Name:	**Date of Birth:**
Phone Number for a pharmacist to contact you with questions:	

Pharmacy Name (Local, Mail Order)	**Address**	**Phone Number** (Include Area Code)

ALLERGIES to Medications, Foods, Environmental Substances	**TYPE OF REACTION**

Do you react to latex or rubber (gloves, paint, condoms, balloons) with a rash, watery eyes or wheezing?
☐ Yes / No ☐

If yes, please explain: _____

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Medication List

MEDICATIONS PRESCRIBED BY YOUR DOCTOR			
Medication Name	Strength/ Dose	Directions on the Bottle	Reason for Taking
Example: Lisinopril	*10 mg*	*Take 2 tablets once daily*	*Hypertension*

NON-PRESCRIPTION MEDICATIONS, VITAMINS, MINERALS, HERBALS, OTHER DIETARY SUPPLEMENTS			
Product Name	Strength/ Dose	How Often You Take the Product	Reason for Taking
Example: Calcium Carbonate	*500 mg*	*Once a day*	*Bone health*
Example: Hydrocortisone Cream	*0.1%*	*1-2 times weekly*	*Itchy skin on arm*

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