Fred Hutch
Cancer Center

**Gastrointestinal Cancer Prevention
Program Intake Form Page**

Full Name ______________________ Date of Birth ____________

Today's date ______________

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: ______________________

Personal History

	Yes	No	
Have you had colon cancer?	☐	☐	When was it diagnosed? ____________ What treatment did you have? ____________
Have you had colon polyps?	☐	☐	When were they diagnosed? ____________ How many did you have?
Were they pre-cancerous (adenomas)?	☐	☐	
When was your last colonoscopy?			____________
How often do you have a colonoscopy?			____________
Do you have polyps in other places, such as your stomach or small intestine?	☐	☐	Where? ____________
Have you had any other type of cancer?	☐	☐	Where was it? ____________ When was it diagnosed? ____________ What treatment did you have? ____________

Do you have a history of:

	Yes	No	
Thyroid Disease	☐	☐	How was it treated? ____________
Sebaceous Cyst	☐	☐	Where? ____________
Lipoma	☐	☐	Where? ____________
Jaw Tumors	☐	☐	When was it diagnosed? ____________
Extra teeth	☐	☐	
Extra finger	☐	☐	
Clubfoot	☐	☐	
Heart Defect	☐	☐	What type? ____________
Lots of moles	☐	☐	
Freckles on or around your lips	☐	☐	About how many? ____________

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PT NO [F]
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Gastrointestinal Cancer Prevention Program Intake Form Page

Do you have, either now or in the past:

Now	Past	
☐	☐	Trouble Swallowing
☐	☐	Frequent or severe nausea
☐	☐	Frequent or severe heartburn
☐	☐	Frequent indigestion
☐	☐	Frequent or sever stomach pain
☐	☐	Frequent or severe vomiting
☐	☐	Vomiting Blood
☐	☐	Yellow Jaundice
☐	☐	Bowel habit change
☐	☐	Prolonged or frequent diarrhea
☐	☐	Constipation
☐	☐	Blood in bowel movements
☐	☐	Black bowel movements
☐	☐	Hemorrhoids (piles)

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

Have you had any recent weight changes? ☐ Yes ☐ No How much? __________ lbs.

Was it voluntary? ☐ Yes ☐ No

Check all that apply to your medical history:

☐	High Blood Pressure	☐	Diabetes	☐	Osteoporosis	☐	Uterine Fibroids
☐	Bleeding	☐	History of Clots	☐	Stroke	☐	Tuberculosis
☐	Heart Disease	☐	Depression	☐	Pneumonia	☐	Liver disease, yellow jaundice, hepatitis

Other major medical illnesses: ____

____

What surgeries have you had, and when? ____

____

Lifestyle History

	Yes	No	Comments
Are you currently married/partnered?	☐	☐	
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?	☐	☐	Please describe: ______________________________
How many meals do eat each day, on average?			
How many hours of sleep do you get each night, on average?			
Do you exercise?	☐	☐	On average, how many hours per week do you regularly exercise? ______________________________ What type of exercise does this primarily include? __________ ______________________________

TEAM

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PT NO [F]

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Fred Hutch Cancer Center

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(Men Only)

	Yes	No	Comments
Have you ever had a Prostate-Specific Antigen (PSA) testing?	☐	☐	If yes, when and what was the result?
Have you ever had a biopsy of your prostate?	☐	☐	If yes, when and where was it performed?
Have you been diagnosed with prostate cancer?	☐	☐	If yes, when?

(Women only) Gynecologic and Reproductive History (Women only)

	Yes	No	Comments
At what age did you have your first period?			
Do you still have periods?	☐	☐	Date of last period:
Are your periods regular?	☐	☐	
Have you ever had vaginal bleeding between period?	☐	☐	
Reason for not menstruating:			
• Natural menopause	☐	☐	
• Hysterectomy	☐	☐	Reason and date: ___ How many ovaries removed: ___
• Breastfeeding	☐	☐	
• Other	☐	☐	Please explain:
Have you had any vaginal bleeding after going through menopause?	☐	☐	☐ Does not apply to me
Have you ever taken estrogen or progesterone after menopause (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?			
Do you have pain with intercourse?	☐	☐	
Do you have pelvic pain?	☐	☐	
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 a bone density evaluation (DEXA scan)?	☐	☐	
Do you have a history of infertility?	☐	☐	
Any gynecological problems or surgeries not already described?	☐	☐	Please explain: ___

TEAM

NAME [M]

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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 ________
Are you planning to have more children? ☐ Yes ☐ No ☐ Undecided	

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?	☐	☐	☐	☐

4. 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	☐	☐	☐	☐

TEAM
NAME [M]
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1. **In the LAST MONTH, have you had an anxiety attack – suddenly feeling fear or panic?**
☐ Yes ☐ No

2. 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?	☐	☐

3. **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	☐	☐	☐

4. **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

5. **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

TEAM
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1. **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

2. **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

3. **How effective are you in coping with your cancer risk? (select one)**
   ☐ Not at all ☐ Slightly effective ☐ Moderately effective ☐ Very effective ☐ Extremely effective

4. **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

5. **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 ______________________________		

(For Fred Hutchinson Cancer Center Use Only)

Reviewed by: ______________________ **Date:** ______________

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UW Medicine

OPT007 (09/22)

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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: ____

TEAM

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PT NO [F]

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OPT007 (09/22)

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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