Adler GYN
Minimally Invasive Surgery

Return Annual Form

Date of Service: _____

Name: _____ Age: _____ Date of Birth: _____

Primary Care Physician: _____

Best Phone no. to reach you: _____ Email: _____

Pharmacy and Location: _____

Reason for Visit:

_____

_____

_____

Last Menstrual Period: _____

How would you describe your periods:

_____

_____

Birth Control: _____

Desire for Future Pregnancy: Yes _____ No _____

Any Medical Problems: _____

Do you wish to have STD / STI testing today: Yes _____ No _____

Any changes in Family History: _____

Allergies to medications: _____

Current Medications: _____

_____

Patient's Signature: _____ Date: _____

For Nurses Only:

Last Pap:		Last HPV:		Last Mammo:		Last DEXA:	
Any prior pelvic sonograms & date:		HX ABNL					
G:		P:		Ab:		Vaginal vs C/sec:	
Previously Seen by AKA:				Family History of Cancer:			
Last annual:				Personal History of Cancer:			

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Health Care Provider:** _____

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☒Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	*—*	*—*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE/ENDOMETRIAL CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*						

☐Y ☐N Are you of Ashkenazi Jewish descent?

☐Y ☐N Are you concerned about your personal and/or family history of cancer?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at age 50 or younger
- ☐ Ovarian cancer at any age
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Pancreatic cancer with a breast or ovarian cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome ** *(see cancer list below)*

- ☐ Colorectal cancer under age 50
- ☐ Endometrial/uterine cancer under age 50
- ☐ MSI High histology*** before age 60
- ☐ Abnormal MSI/IHC tumor test result *(colon/rectal/endometrial/uterine)*
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ YOU and one or more relatives with a Lynch syndrome cancer**

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Close relative with breast cancer less than age 50
- ☐ Close relative with ovarian cancer at any age
- ☐ Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- ☐ A male relative with breast cancer
- ☐ Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- ☐ Three or more relatives with breast cancer at any age
- ☐ A previously identified *BRCA1* or *BRCA2* mutation in the family

Lynch Syndrome ** *(see cancer list below)*

- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age
- ☐ A previously identified Lynch syndrome mutation in the family

*HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

**Lynch syndrome cancer includes: *Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas*

***MSI High histology includes: *Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern*

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? ☐YES ☐NO ☐ACCEPTED ☐DECLINED

Follow-up appointment scheduled: ☐YES ☐NO Date of Next Appointment: _____

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Recent Office Updates

FOR YOUR CONVENIENCE

- **ANNUAL VISITS ONLY COVER A BREAST AND PELVIC EXAM –**
  Other issues such as heavy bleeding, pelvic pain, hormones ect. must be addressed in another appointment. If discussed, the co-insurance is the responsibility of the patient to be paid.

  _____
  Initial above

  - MEDICAID PLAN FIRST ONLY PAYS FOR FAMILY PLANNING VISITS
  - DR. ADLER NO LONGER PRACTICES OBSTETRICS (NO BABIES)

- IF THERE HAS BEEN A **CHANGE** OF ADDRESS, TELEPHONE NUMBER, OR INSURANCE ETC. **PLEASE INFORM RECEPTIONIST AS SOON AS POSSIBLE**
- THIS IS OUR **ONLY** LOCATION. WE ARE OPEN **MONDAY - THURSDAY** FROM 7:30- 5:00 PM
- WE ARE CLOSED FOR **LUNCH** BETWEEN **12:00-1:00PM** (Phones are qued to shut off)
- WE ACCEPT ALL INSURANCES **EXCEPT** KAISER PERMANENTE
- IF YOU HAVE A BALANCE, YOU WILL **NOT** BE SEEN OR SCHEDULED AN APPOINTMENT UNTIL THE BALANCE IS PAID. FINANCE CHARGES WILL BE APPLIED
- IF BALANCE IS NOT PAID, IT WILL BE SENT TO **COLLECTIONS** AND YOU WILL BE CHARGED AN **ADDITIONAL 33.33% OF BILL ON TOP OF YOUR CURRENT BILL**
- **NO SHOW APPOINTMENTS WILL BE CHARGED A $50 FEE. Please call within 48 hours to cancel or reschedule your appointment.**

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE RECEIVED THESE UPDATES

PATIENT SIGNATURE_____ DATE _____

*IF YOU WOULD LIKE A COPY FEEL FREE TO ASK RECEPTIONIST