Baseline Medical History

Introductory Notes

The following document is a PDF rendering of the online Baseline Medical History (BMH) survey for female patients. Some pages are longer than others as selections representing common or clinically significant answers have been made to display follow-up questions. For the same reason, the survey in the PDF is much longer than would be experienced by almost all patients. In some cases, unrealistic answer combinations have been selected for demonstration purposes. Also, note that the page indexing displayed at the bottom of each page is inaccurate in this version because pages common to both the male and female versions were taken from the male survey.

Medical History (BMH)

0%

Welcome to Memorial Sloan-Kettering Cancer Center

In this questionnaire we will ask you about your medical history. Your responses will be part of your medical record, which means you won't have to answer the same questions again when you see your healthcare providers at MSK. By completing this form at home you can take your time to be sure you have all the information you need, and you won't have to come in early for your doctor's appointment to provide the information then. It'll take about a half hour to fill out this form, but you can take a break and come back to it as many times as you need to.

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Medical History (BMH)

3%

About You

We have recorded the following:

Your sex as: **NotKnown**

Your ethnicity as: Not available

And your race as: Not available

- ( ) Correct
- (•) Incorrect, I want to make a change.

Please make your changes below:

Ethnicity:

- ( ) Hispanic or Latino
- ( ) Not Hispanic or Latino

Race:

- ( ) White
- ( ) Black – African American
- ( ) Native American – American Indian/Alaska Native North/Central/South America
- ( ) Asian – Far East/Indian Subcontinent
- ( ) Native Hawaiian – Other Pacific Islander
- ( ) Other
- ( ) Decline to answer

Would you like us to know anything else about your gender?

- ( ) Yes
- ( ) No

What name would you like the staff to call you?

What is your sexual orientation?

- ( ) Heterosexual
- ( ) Homosexual
- ( ) Bisexual
- ( ) Other
- ( ) Prefer not to answer

What is your current marital status?

- ( ) Married
- ( ) Divorced
- ( ) Domestic Partnership
- ( ) Separated
- ( ) Single
- ( ) Widowed

Do you have any children?

- ( ) Yes
- ( ) No

Medical History (BMH)

7%

About You

Do you see or talk with anyone at least once a day? ◯ Yes ◯ No

Which of the following best describes your living situation?

- ◯ Living alone
- ◯ Living with family or partner
- ◯ Assisted living facility
- ◯ Nursing home
- ◯ Living with someone who is not family or my partner
- ◯ Other

What is the total number of people living in your household? Select

How would you describe your current employment situation? ◉ Working ◯ Not Working

What is your current employment status?

- ◉ Currently working in at least one FULL time job (35 hours or more per week)
- ◯ Currently working in at least one PART time job (less than 35 hours per week)

What is your current job title? If you have more than one job please tell us about your primary job.

What kind of work do you do? Please describe your current job in two sentences or less. If you have more than one job, please tell us about your primary job.

Does your job have sick leave pay (paid sick days)? ◉ Yes ◯ No ◯ Don't Know

How many sick days do you get at your job?

- ◯ Fewer than 10 days
- ◯ 10-15 days
- ◯ 16-20 days
- ◯ More than 20 days
- ◯ Don't know

Does your job have disability pay? ◉ Yes ◯ No ◯ Don't Know

Since your diagnosis have you ever been on leave with disability? ◯ Yes ◯ No ◯ Don't Know

Are you self-employed? ◯ Yes ◯ No

Medical History (BMH)

10%

About You

Is there anything significant happening in your life you would like us to know about?

In what language do you prefer to discuss your health care? Select

Do you require an interpreter? ◯ Yes ◯ No

Contact Information

What is the best telephone number to reach you?

Is it okay for us to leave a message on your voicemail? ◯ Yes ◯ No

Is it okay to communicate via text message? ◯ Yes ◯ No

If there is another telephone number that you sometimes use, please enter it here

If you have an email address, please enter it here:

Is it okay if we email you with information or questions about your health or care at Memorial Sloan-Kettering Cancer Center? We will not email you for “marketing” or “fundraising” purposes. ◯ Yes ◯ No

Emergency Contact

Do you have someone to help you if you get sick or in an emergency? ◯ Yes ◯ No

What is the name of your caregiver, the primary person who will be helping to look after you during your treatment?

What is your caregiver's relation to you?

What is the best telephone number to call your caregiver on?

If there is anyone else who will be helping with your care, other than your main care partner, please give their details here.

Name:

Relationship:

Phone:

Medical History (BMH)

13%

About You

How old were you when you had your first menstrual period?
(Make a best guess if unsure)

Do you still get your period?
- Yes
- No

How long has it been since the end of your last menstrual period?
- In the last week
- 1-3 weeks
- 4-6 weeks
- 6-12 weeks
- 3 months or more

Are you pregnant?
- Yes
- No
- Unsure/Possibly

Are you breast feeding?
- Yes
- No

How old where you when you had your last menstrual period?

Do you or did you take hormone replacement?
- Yes
- No

Have you had bleeding after menopause?
- Yes
- No

How old were you when you first gave birth?
- No live births
- Younger than 20
- 20-24
- 25-29
- 30 or Older

Do you or did you take birth control pills?
- Yes
- No

Medical History

We now want to ask you about any medical problems you may have had.

There is no need to tell us about symptoms related to your cancer. If you are unsure about whether to tell us about something, mark it down. We will ask you more when you come in for your appointment.

Heart Disease

Have you ever been told that you have a problem with your heart, or have been treated for heart disease, chest pain or angina? (●) Yes ( ) No

Blood Thinners

Are you on medication, such as aspirin or Coumadin to thin your blood because of a problem with your heart? ( ) Yes ( ) No

Angina

Have you ever had chest pain, also known as angina? ( ) Yes ( ) No

Blocked Artery

Have you ever had surgery or a stent placed to treat a blocked artery? ( ) Yes ( ) No

Congestive Heart Failure

Have you ever been diagnosed with congestive heart failure (CHF), been told that you have a "weak heart" or "water in the lungs", or have you ever been prescribed a "water pill" for your heart? ( ) Yes ( ) No

Heart Attack

Have you ever had a heart attack? ( ) Yes ( ) No

Heart valve problems

Have you ever been told you have a problem with a valve in your heart, such as aortic stenosis or a blockage in one of your heart valves? ( ) Yes ( ) No

Atrial Fibrillation

Have you ever been told you have atrial fibrillation (A Fib) or an irregular heartbeat? ( ) Yes ( ) No

Abdominal Aortic Aneurysm

Have you ever been diagnosed with an abdominal aortic aneurysm, or been told that you have a widening of a major artery in your abdomen? ( ) Yes ( ) No

Check this box if you are unsure what your heart problem is or if it is not listed above. [ ] Yes

Peripheral Vascular Disease

Have you ever had pain in your legs related to poor circulation, or have been diagnosed with peripheral vascular disease or claudication ("pain on walking")? (●) Yes ( ) No

When? Please select the year (up to three). If you are unsure, please take your best guess.

Year of your first "pain on walking": Year

Year of your second "pain on walking": Year

Year of your third "pain on walking": Year

Have there been additional times when you had pain in your legs related to poor circulation? ( ) Yes ( ) No

Deep Venous Thrombosis

Have you had a deep venous thrombosis? ( ) Yes ( ) No

Pulmonary Embolus

Have you ever had a blood clot in your lungs or a pulmonary embolus? (●) Yes ( ) No

When? Please select the year (up to three). If you are unsure, please take your best guess.

Year of your first blood clot in lungs or pulmonary embolus: Year

Year of your second blood clot in lungs or pulmonary embolus: Year

Year of your third blood clot in lungs or pulmonary embolus: Year

Have there been additional times when you had a blood clot in your lungs or a pulmonary embolus? ( ) Yes ( ) No

Medical History (BMH)

17%

Medical History

There is no need to tell us about symptoms related to your cancer. If you are unsure about whether to tell us about something, mark it down. We will ask you more when you come in for your appointment.

Hypercholesterolemia

Have you ever been told that you have high cholesterol? ○ Yes ○ No

Hypertension

Have you ever been told that you have high blood pressure (diagnosed with hypertension)? ○ Yes ○ No

TIA

Have you ever had a “mini stroke” or a TIA or been treated with blood thinners for a “mini stroke”? ○ Yes ○ No

Stroke

Have you ever had a stroke (other than a TIA)? ◉ Yes ○ No

Did the stroke involve bleeding in the brain (hemorrhage) or a blood clot (infarction, thrombosis or embolism)?

☐ Bleeding ☐ Blood clot ☐ I'm not sure

When? Please select the year (up to three). If you are unsure, please take your best guess.

Year of your first bleeding in the brain or blood clot: Year

Year of your second bleeding in the brain or blood clot: Year

Year of your third bleeding in the brain or blood clot: Year

Have there been additional times when you had a stroke (other than a TIA)? ○ Yes ○ No

Asthma

Have you ever been diagnosed with asthma? ◉ Yes ○ No

When were you first diagnosed? If you are unsure, please take your best guess. Year

What severity of asthma describes your illness?

○ Mild = does not interfere with daily activities ○ Moderate = some interference with daily activities ○ Severe = major impact

Approximately how often do you use a rescue inhaler for your asthma?

○ Rarely or never ○ Less than once a week ○ Once a week
○ Multiple times per week ○ Once a day ○ Multiple times a day
○ Don’t have a rescue inhaler

Have you ever taken oral steroids to control your asthma? ○ Yes ○ No

Have you ever been admitted to the intensive care unit (ICU) or had a breathing tube intubated (had a tube inserted in your throat) because of your asthma? ○ Yes ○ No

COPD

Have you ever been told you have chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, or “smoker’s lung”? ○ Yes ○ No

Sleep Apnea

When you sleep, do you often snore louder than your indoor speaking voice or loud enough to be heard through closed doors? ○ Yes ○ No

Has anyone ever observed you stop breathing while asleep? ○ Yes ○ No

Medical History (BMH)

21%

Medical History

There is no need to tell us about symptoms related to your cancer. If you are unsure about whether to tell us about something, mark it down. We will ask you more when you come in for your appointment.

Mental Health

Have you ever had or been treated for emotional or mental health problems such as depression or anxiety?

(●) Yes ( ) No

Check all that apply:

- [ ] Depression
- [ ] Anxiety
- [ ] Other

Neurologic Problems

Have you ever had or been treated for migraines, seizures, balance problems, neuropathy or any other problems with your brain or nerves other than cancer?

(●) Yes ( ) No

Check all that apply:

- [ ] Migraine
- [ ] Seizures
- [ ] Balance problems
- [ ] Neuropathy
- [ ] Other

Gastrointestinal Problems

Have you ever had or been treated for problems with your stomach or bowels, such as a gastric or duodenal ulcer, Crohn's disease, diverticulitis, or reflux? (Do not include cancer.)

(●) Yes ( ) No

Check all that apply:

- [ ] Gastric Ulcer
- [ ] Ulcerative colitis or Crohn's disease
- [ ] Diverticulitis
- [ ] Reflux
- [ ] Irritable bowel syndrome
- [ ] Jaundice
- [ ] Other

Musculoskeletal Pain

Have you ever had or been treated for pain in your muscles or bones, such as low back pain or arthritis?

(●) Yes ( ) No

Check all that apply:

- [ ] Back pain
- [ ] Neck pain
- [ ] Arthritis
- [ ] Rheumatoid arthritis
- [ ] A broken bone
- [ ] A soft tissue injury
- [ ] Unsure
- [ ] Other

Medical History (BMH)

27%

Medical History

Obstetrics and Gynecology

Have you ever had or been treated for problems, other than cancer, with your period (menstruation) or pregnancy? ◉ Yes ○ No

Check all that apply:

- ☐ Difficulties getting pregnant
- ☐ Miscarriage
- ☐ Painful or heavy menstrual periods
- ☐ Endometriosis
- ☐ Ovarian cyst
- ☐ Fibroids
- ☐ Other

Genitourinary

Other than cancer, have you ever had or been treated for problems, with your kidney, bladder, or urination? ◉ Yes ○ No

Check off all that apply:

- ☐ Kidney stones
- ☐ Chronic kidney disease
- ☐ Problems with urination
- ☐ Urinary tract infection
- ☐ Incontinence
- ☐ Other

Other cancers

Other than the cancer you are being seen for now, have you been told you had any of the following

- ☐ Bladder cancer
- ☐ Brain cancer
- ☐ Breast cancer, breast abnormalities or carcinoma in situ
- ☐ Colon or rectal cancer
- ☐ Head and neck cancer
- ☐ Kidney cancer
- ☐ Leukemia
- ☐ Liver cancer
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Pancreatic cancer
- ☐ Skin cancer
- ☐ Stomach cancer
- ☐ Thyroid cancer
- ☐ Cervical cancer
- ☐ Ovarian cancer
- ☐ Uterine cancer
- ☐ Other cancer

Have you ever had prior chemotherapy? ○ Yes ○ No

Have you ever received radiation therapy (not including x-rays or CT scans) to treat a medical problem? ○ Yes ○ No ○ Don't Know

Do you have any other health problems or symptoms that you would like to tell us about? If so tell us a little bit about how long you've had it. There is no need to tell us about symptoms related to your cancer.

Medical History (BMH)

27%

Surgical History

Have you ever had a surgical procedure in which you were anesthetized (i.e. put to sleep)? (•) Yes ( ) No

Select from the following list:

- [ ] **Appendectomy**: Removal of the appendix to treat acute appendicitis.
- [ ] **Bariatric surgery**: Procedures such as stapling the stomach to lose weight.
- [ ] **Carotid endarterectomy**: Surgery to remove blockage from blood vessels in the neck, to prevent stroke.
- [ ] **Coronary artery bypass**: Heart surgery for angina (chest pain) or heart disease.
- [ ] **Hemorrhoidectomy**: Surgical removal of hemorrhoids, distended veins in the lower rectum or anus.
- [ ] **Joint replacement**: Such as an artificial hip or knee.
- [ ] **Lower back surgery**: Any surgery for lower back pain, including removal of a disk, removal of bone ("laminectomy") or fusion.
- [ ] **Partial Prostatectomy**: Surgical removal of part of the prostate gland as a treatment for benign enlargement of the prostate.
- [ ] **Radical Prostatectomy**: Surgical removal of all of the prostate gland as a treatment for cancer.
- [ ] **Polypectomy**: Removal of polyps from the colon.
- [ ] **Colon surgery**: Removal of part of the large intestine to treat cancer of the colon or ulcerative colitis or diverticulitis.
- [ ] **Surgery for a hernia**: A protrusion of the intestines or fatty tissue into the groin or belly

Have you had any other surgical procedures or treatments that are not on this list? ( ) Yes ( ) No

Anesthesia Reactions

Have you ever had problems with anesthesia? ( ) Yes ( ) No

Have you ever been told there was a problem inserting a breathing tube during anesthesia? ( ) Yes ( ) No

Have you ever had a prolonged sore throat or dental injury after anesthesia? ( ) Yes ( ) No

Medical History (BMH)

31%

Allergies

Do you have allergies to medications, foods, herbal products, latex, or anything else?

(•) Yes ( ) No

Please list the agent and describe the reaction below.

	Allergic to:	Reaction:
−		

+

Do you have any other allergies not listed here that cause more than minor symptoms (such as a mild rash or eye irritation)?

( ) Yes ( ) No

Medical History (BMH)

34%

Your Current Health

Reminder

You are halfway through giving us your medical history. Remember that you can stop at any point and click the link in your email to return to the survey. The computer will remember where you last were and will resume there.

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Medical History (BMH)

37%

Your Current Health

Now that we understand your past medical history, it is important for us to know about any current problems that you have.

What is your particular concern for today's visit?

Pain

Do you have pain now? ◯ Yes ◯ No

Are you satisfied with your current method of managing your pain? ◯ Yes ◯ No

Infection/Isolation

Do you have any active infections right now? ◯ Yes ◯ No

Fever

Have you had any unexplained fevers in the past month? ◯ Yes ◯ No

Fatigue

Have you been feeling unexpectedly tired in the past month? ◯ Yes ◯ No

Headaches

Have you had headaches in the past month? ◉ Yes ◯ No

For how long have you been having headaches?

◯ A month or less ◯ Several months ◯ About a year ◯ More than a year

Are the headaches worse when you first wake up? ◯ Yes ◯ No ◯ Unsure

Have your headaches been getting worse in the past month? ◯ Yes ◯ No ◯ Unsure

How long do your headaches usually last? ◯ Minutes ◯ Hours ◯ Days

Where is the pain? (check all that apply)

- ☐ Back of the head
- ☐ Eyes
- ☐ Temples
- ☐ Forehead

Medical History (BMH)

41%

Your Current Health

Abdominal Pain

Have you experienced any unexplained pain in your stomach area in the past month?

- (●) Yes
- ( ) No

How long has this been happening?

- ( ) A month or less
- ( ) Several months
- ( ) About a year
- ( ) More than a year

Has it been getting worse in the past month?

- ( ) Yes
- ( ) No
- ( ) Unsure

Nausea

Have you been feeling nauseous or have you been vomiting?

- ( ) Yes
- ( ) No

Loss of Appetite

During the past 2 weeks, have you been eating half or less than half of what you usually eat?

- ( ) Yes
- ( ) No

Weight Change

Have you had unintentional weight loss or weight gain of more than 10 lbs (5 kg) within last 3 months?

- ( ) Yes, weight gain
- ( ) Yes, weight loss
- ( ) No

Medical History (BMH)

44%

Your Current Health

Mouth Sores

Have you experienced any mouth sores in the past month? (•) Yes ( ) No

How long has this been happening?

( ) A month or less ( ) Several months ( ) About a year ( ) More than a year

Has it been getting worse in the past month? ( ) Yes ( ) No ( ) Unsure

Difficulty Swallowing

Are you having difficulty swallowing food or liquids? ( ) Yes ( ) No

Coughing

Have you had any unexplained coughing in the past month? ( ) Yes ( ) No

Shortness of Breath

Have you been short of breath in the past month? ( ) Yes ( ) No

Medical History (BMH)

48%

Your Current Health

Dysuria

Have you experienced pain when you urinate? ○ Yes ○ No

Urinary Frequency

Have you found it difficult to postpone urination, had to urinate within two hours of finishing or leaked or dripped urine? ◉ Yes ○ No

How long has this been happening?

○ A month or less ○ Several months ○ About a year ○ More than a year

Has it been getting worse in the past month? ○ Yes ○ No ○ Unsure

Urinary Continence

In the past year, have you ever lost your urine and gotten wet? ○ Yes ○ No

Medical History (BMH)

51%

Your Current Health

Diarrhea

Have you had diarrhea for greater than 2 weeks? ◯ Yes ◯ No

Constipation

Have you had constipation for greater than 2 weeks? ◯ Yes ◯ No

Bloody Bowel Movements

Have you noticed any blood in your stool, or have your stools been black, in the past month? ◯ Yes ◯ No

Change in Bowel Movements

How often do you have a bowel movement per day? [▾]

Have your bowel movements become more or less frequent in the past month?

◯ More frequent ◯ Less frequent ◯ The same

Medical History (BMH)

55%

Your Current Health

Joint Pain

Are you currently experiencing any pain in your muscles or joints?

(●) Yes ( ) No

How long has this been happening?

( ) A month or less ( ) Several months ( ) About a year ( ) More than a year

Has it been getting worse in the past month?

( ) Yes ( ) No ( ) Unsure

Adenopathy

Have you had any swollen glands or lymph nodes in the past month?

( ) Yes ( ) No

Swollen Legs

Have you experienced swelling in your legs, feet or ankles in the past month?

( ) Yes ( ) No

Open Wounds/Skin Breakdown

Do you have any open wounds or areas of skin breakdown?

( ) Yes ( ) No

Areas of Redness/Swelling

Do you have any areas of redness or swelling?

( ) Yes ( ) No

Medical History (BMH)

58%

Your Current Health

Rash

Have you had a rash or skin problems in the past month? (•) Yes ( ) No

How long has this been happening?

( ) A month or less ( ) Several months ( ) About a year ( ) More than a year

Has it been getting worse in the past month? ( ) Yes ( ) No ( ) Unsure

Heat/Cold Intolerance

Have you found yourself feeling more hot or cold than others in the room with you in the past month? ( ) Yes ( ) No

Hot Flashes

Have you experienced hot flashes or night sweats in the past month? ( ) Yes ( ) No

Thirst

Have you been continually thirsty in the past month? ( ) Yes ( ) No

Medical History (BMH)

62%

Your Current Health

Your Current Health

Do you have a fear of falling? ○ Yes ○ No

Focal Weakness

Do you have any weakness in your arms, hands or legs or have you noticed any changes in how you walk in the past month? ○ Yes ○ No

Do you have numbness and/or tingling in your feet that affects mobility? ○ Yes ○ No

Balance

Do you have problems with your balance or would you have difficulties running for a bus if you had to? ○ Yes ○ No

Have you fallen at any time in the past year? ◉ Yes ○ No

How many times have you fallen? ○ One time ○ More than one time

Where was your last fall? ○ Home ○ Outside

Do you need help walking to the exam room or getting in the chair or onto the table? ○ Yes ○ No

Do you have difficulty or are you unsteady when walking or climbing stairs? ○ Yes ○ No

Do you have any weakness in your legs or that affects one side of your body? ○ Yes ○ No

Do you use any of the following devices? (check all that apply)

☐ None ☐ Cane ☐ Walker ☐ Crutches
☐ Wheelchair ☐ Brace ☐ Prosthesis

Please select the one phrase that best describes you at this time.

○ Normal, no symptoms
○ Able to carry on normal activity, minor symptoms
○ Normal activity, with effort, some symptoms of disease
○ Can care for self, but unable to do normal activity or work
○ Require occasional assistance, but able to care for most needs
○ Require considerable assistance
○ Require special care and assistance
○ Require continuous nursing care

Medical History (BMH)

65%

Your Current Health

Do you have home care services now?

- ◯ Yes
- ◯ No

Do you use oxygen at home?

- ◯ Yes
- ◯ No

Do you have any implants? Select all that apply.

- ☐ None
- ☐ Port
- ☐ Catheter
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Stent
- ☐ Other

Do you have any metal, such as a joint replacement or even shrapnel, in your body?

- ◯ Yes
- ◯ No

Emotional Health

During the past 2 weeks, how often have you been bothered by having little interest or pleasure in doing things?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

During the past 2 weeks, how often have you been bothered by feeling depressed?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

During the past 2 weeks, how often have you been bothered by feeling panicked and anxious?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

During the past 2 weeks, how often have you been bothered by feeling hopeless?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Within the past 24 hours, have you used any medications for sleeping problems, anxiety, sedation, or to control seizures?

- ◯ Yes
- ◯ No

Medical History (BMH)

68%

Health Maintenance/Disease Screening

There is no need to tell us about symptoms related to your cancer. If you are unsure about whether to tell us about something, mark it down. We will ask you more when you come in for your appointment.

Cholesterol

Do you know, about what your level of total cholesterol is? If you are taking pills for your cholesterol, tell us about your cholesterol when you are on the pills.

- ◯ High (>270 mg/dL)
- ◯ Medium (200-270 mg/dL)
- ◯ Normal (<200 mg/dL)
- ◯ Not sure

Do you know about what your level of HDL ("good") cholesterol?

- ◯ Very Low (<20 mg/dL)
- ◯ Low (21-60 mg/dL)
- ◯ Normal (> 60mg/dL)
- ◯ Not sure

Blood Pressure

Blood pressure is often described as one number "over" another, such as "115 over 70". If you know your blood pressure, about, what is the first (higher) number? If you are taking pills for your blood pressure, tell us about your blood pressure when you are on the pills.

- ◯ High (>=160 mm Hg)
- ◯ Elevated (140-159 mm Hg)
- ◯ Normal/Low (<140 mm Hg)
- ◯ Not sure

What is the second (lower) number?

- ◯ High (>=100 mm Hg)
- ◯ Elevated (90-99 mm Hg)
- ◯ Normal/Low (<90 mm Hg)
- ◯ Not sure

Diabetes

Have you ever been diagnosed with diabetes?

- ◉ Yes
- ◯ No

When were you diagnosed with diabetes? Please select the month and year. If you are unsure, please take your best guess.

Month: Month Year: Year

How do you manage your diabetes?

- ◯ Diet controlled
- ◯ Oral medicine
- ◯ Insulin
- ◯ Oral medicine and insulin

Medical History (BMH)

75%

Health Maintenance/Disease Screening

There is no need to tell us about symptoms related to your cancer. If you are unsure about whether to tell us about something, mark it down. We will ask you more when you come in for your appointment.

Cancer Screening

Have you had a colonoscopy or sigmoidoscopy (where a doctor uses a special camera to look at your bowels) to check for colon cancer?	◯ Yes	◯ No
Have you had a mammogram?	◯ Yes	◯ No
Have you ever had a breast biopsy?	◯ Yes ◯ No	◯ Unknown
Have you had a pap smear?	◯ Yes	◯ No
Have you ever been tested for BRCA1 or BRCA2?	◯ Yes ◯ No	◯ Don't Know
Have you had a fecal occult blood test for colon cancer (FOBT)? This is where a doctor examines your stool to look for blood.	◯ Yes	◯ No

Medical History (BMH)

79%

Your Lifestyle

Tell us a little bit more about yourself and your everyday habits.

For this next question, we would like you to recall your average weekly exercise behavior over the past month. Considering a typical week (7 days) how many times on average, did you perform the following kinds of exercise?

When answering these questions please:

- Only count exercise sessions that lasted 20 minutes or longer in duration

- Only count exercise that was done during free time (i.e., not occupation or housework)

- Note that the main difference between the three categories is the intensity of the exercise

Strenuous exercise (heart beats rapidly, sweating) (e.g., running, aerobics classes, vigorous swimming or bicycling)	Time Per Week (0-7)	Average Duration (mins)
Moderate exercise (not exhausting, light perspiration) (e.g., fast walking, tennis, easy bicycling, easy swimming)	Time Per Week (0-7)	Average Duration (mins)
Mild exercise (minimal effort, no perspiration) (e.g., easy walking, yoga, golf)	Time Per Week (0-7)	Average Duration (mins)

As part of your job, housework do you engage in 10 minutes or more of continuous physical activity, such as brisk walking, washing windows or lifting?

- (•) Yes
- ( ) No

In a typical week, how many minutes/hours per week of vigorous activity, such as digging or lifting heavy loads that causes large increases in your breathing or heart rate?

In a typical week, how many minutes/hours per week of moderate activity, such as brisk walking, lifting light loads, vacuuming or washing windows, that causes moderate increases in your breathing or heart rate?

Alcohol Use

In a typical week, how many alcoholic drinks do you have? One “drink” is defined as 12 ounces of beer (a standard bottle), a 4 ounce glass of wine (standard wine glass) or 1½ ounces of liquor or spirits (a “single” or “shot”).

- ( ) I never drink
- ( ) I do drink, but less than once a week
- ( ) One or two a week
- ( ) About one a day
- ( ) About two or three a day
- ( ) Four or more a day

Medical History (BMH)

82%

Your Lifestyle

The following questions are about your smoking history. To help you think about this, remember that one pack typically includes 20 cigarettes.

Please identify your smoking history by choosing one of the listed items below:

- ( ) I have never smoked
- ( ) I am a former smoker
- (•) I currently smoke periodically, yet consistently

I have smoked at least 100 cigarettes during my lifetime.

- ( ) I currently smoke everyday
- ( ) Current smoking status unknown
- ( ) Previous and current smoking status unknown

At what age did you start smoking? [ ]

What is the average number of cigarettes packs you smoke per day? [ ]

Do you use tobacco products other than cigarettes? ( ) Yes ( ) No

Medical History (BMH)

86%

Your Lifestyle

Are you currently living with a smoker?	○ Yes	○ No
In the past 30 days, have you worked in a place where other people smoked cigarettes indoors?	○ Yes	○ No
Thinking of all your childhood and adult years, have you ever lived in a place where other people smoked cigarettes indoors?	○ Yes	○ No
Thinking of all the years you have worked, have you ever worked in a place where other people smoked cigarettes indoors?	○ Yes	○ No
Have you ever lived in a home where someone smoked?	◉ Yes	○ No
For how many years, in total, have you shared your home with a smoker?		

Medical History (BMH)

89%

Your Lifestyle

Special Issues

Are you receiving a tube feeding? ○ Yes ○ No

Do you have any special dietary needs? ◉ Yes ○ No

Specified dietary needs

☐ Nutritional supplements ☐ Diet for diabetes ☐ Diet for kidney disease ☐ Vegetarian
☐ Kosher ☐ Halal ☐ Gluten-free

Other:

Are you unable to care for yourself and have no one to help you? ○ Yes ○ No

Would you like to speak to someone about talking with your minor children about cancer? ○ Yes ○ No

Would you like to speak to someone about talking with your family/friends/partner about cancer? ○ Yes ○ No

Are you or your family currently at risk for domestic violence or child/elder abuse/neglect? ○ Yes ○ No

Would you like to speak to someone about your need for transportation to medical appointments? ○ Yes ○ No

Would you like to speak to someone about temporary lodging during treatment? ○ Yes ○ No

Would you like to speak to someone about your ability to pay for your medical treatment? ○ Yes ○ No

Are there any religious, cultural, or spiritual practices that are important to you during your course of treatment? ◉ Yes ○ No

We have staff trained to provide spiritual support. Would like them to contact you by telephone? ○ Yes ○ No

Do you have any religious, spiritual, or cultural beliefs that would affect your care? ◉ Yes ○ No

Please describe the beliefs.

Do you have an Advanced Directive (Health Care Proxy)? ○ Yes ○ No

Are you planning to receive treatment at MSK? ○ Yes ○ No ○ Unsure

Medical History (BMH)

93%

Family History - Medical Problems in Your Family

Please tell us here if any immediate family member has been diagnosed with any of the following conditions.

- [x] High blood pressure
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
- [x] High cholesterol
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
- [x] Diabetes
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
- [x] Stroke
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
  - Have you had a female relative who was told they had a stroke before the age of 65, or a male relative told they had a stroke before the age of 55? ( ) Yes ( ) No
- [x] Seizures
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
- [x] Heart attack
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
  - Have you had a female relative who was told they had a heart attack before the age of 65, or a male relative told they had a heart attack before the age of 55? ( ) Yes ( ) No
- [x] Heart disease requiring surgery
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
  - Have you had a female relative who was told they had a heart disease requiring surgery before the age of 65, or a male relative told they had a heart disease requiring surgery before the age of 55? ( ) Yes ( ) No
- [x] Bleeding or Clotting disorder
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle
- [x] Other Genetic Disorder
  - Please describe the other genetic disorder:
  - Please indicate which relative
  - [ ] Child [ ] Sibling [ ] Parent [ ] Grandparent [ ] Aunt/Uncle

Have any of your family members ever been diagnosed with cancer? (•) Yes ( ) No ( ) Don't Know

How many relatives related to you by blood have been diagnosed with bladder cancer?

How many first degree relatives (mother, sister or daughter) have had breast cancer?

Please give us a little bit more information, telling us how you are related to the family member with cancer, the type of cancer it was and whether your relative died from the cancer:

Have you ever been tested for any hereditary cancer syndromes? (•) Yes ( ) No ( ) Don't Know

What were the results?

Breast cancer panel (other than BRCA1/2)	( ) Not Tested	( ) Positive	( ) Negative
Colon cancer (Lynch Syndrome)	( ) Not Tested	( ) Positive	( ) Negative
Colon cancer panel (other than Lynch Syndrome)	( ) Not Tested	( ) Positive	( ) Negative
Stomach cancer	( ) Not Tested	( ) Positive	( ) Negative
Kidney cancer	( ) Not Tested	( ) Positive	( ) Negative
Other Hereditary cancer syndrome	( ) Not Tested	( ) Positive	( ) Negative

Please describe the other hereditary cancer syndrome:

Medical History (BMH)

96%

Survey Complete

You have just completed the survey. We look forward to meeting with you and discussing your responses when you come in for your visit. If you have any feedback so we can improve the Base Medical History experience, please use the space below to list them. Please note that no one involved in your care will see any text you enter below.

Who completed the questionnaire?

- ◯ I did it by myself.
- ◯ I did it with the help of others.
- ◯ Someone else completed the questionnaire because I couldn't do it.

Please enter your feedback here:

Thank you. Please click the Submit button.