



ELHAMY D. ESKANDER, M.D., F.A.C.P. MARK G. GOLDSTEIN, M.D. BRIAN M. O'CONNOR, M.D.
MICHELLE MILLER, R.N. PATRICIA A. RICE, C.R.N.P., O.C.N.
(301) 662-8477 FAX (301) 662-4293

Dear Patient:

Thank you for your interest in the **Cancer Risk Assessment Program** at Oncology Care Consultants of the Frederick Memorial Hospital Regional Cancer Therapy Center. We are located at 501 West 7th St., Suite 1A, Frederick, MD 21701.

Enclosed are several forms, our Personal and Family History Questionnaires and our Consent for Release of Medical Information. Please complete the Personal Medical History and Family History forms. Any additional documentation you can provide to support your medical history, such as pathology reports and medical records, are always appreciated.

Once you have completed these forms, please return them to the **Attention of Patricia Rice, C.R.N.P.** at the address listed below. (It is imperative that we receive your paperwork **two to four weeks in advance** so that the proper preparation can be made for your visit).

At that time, please call the office at (301) 662-8477 and schedule a one hour appointment with Ms. Rice for two to four weeks in the future. Appointments are available Monday through Thursday at our main location listed below. Appointments can also be scheduled every Monday from 9:00 - 11:00 a.m. at The Women's Center at FMH Crestwood at 7211 Bank Court in Frederick.

If you have any questions, or require assistance in completing the paperwork, you may contact Patricia Rice, our Nurse Practitioner, at (301) 662-8477.



Cancer Risk Assessment Program Personal Medical History

Please complete this questionnaire. When asked for results of tests, please provide copies of actual test results if possible. If there are any questions which do not apply to you, please answer with NA (not applicable). If you have any questions regarding this questionnaire please contact Patricia Rice, C.R.N.P., at (301) 662-8477.

Name: _____

Date of birth: _____

Reason for seeking cancer risk assessment: _____

Ethnic/Racial background: _____

Are you of Ashkenazi Jewish (Middle European) decent? Yes No

Past Medical History:

Birth Defects: _____

Illnesses: _____

Operations/ Include Breast Biopsies and Results: _____

Have you or anyone in your family been diagnosed with
familial polyposis (FAP)? Yes No

Have you ever had an upper endoscopy to look at your stomach? Yes No

Date of test and results: _____

Do you have annual skin exams? Yes No

Have you ever been diagnosed with benign skin moles or skin cancer? Yes No

If yes, please provide date and results: _____

Breast and Reproductive history (Women only):

Do you have annual clinical breast exams by a health practitioner? Yes No

Do you perform self-breast exams regularly (at least every 2 months)? Yes No

Have you or your practitioner found any abnormal lumps? Yes No

If yes, explain: _____

Do you have annual mammograms? Yes No

Date of last mammogram: _____

Have you ever had an abnormal mammogram? Yes No

If yes, provide date and results: _____

Do you have annual pap and pelvic exams? Yes No

Date of last exam: _____

Do you still have your uterus and ovaries? Yes No

If not, provide date, type of surgery, and reason for surgery: _____

Have you ever had a biopsy of the uterus? Yes No

If yes, provide date and results: _____

Have you ever had an abnormal pap or pelvic exam? Yes No

If yes, provide date and results of exam: _____

Have you ever had a sonogram of the uterus or ovaries? Yes No

If yes, provide date and results: _____

Have you ever had a CA-125 blood test? Yes No

If yes, please provide date and results: _____

How old were you when you had your first period? _____

If you have stopped having your periods, how old were you when they stopped? _____

Have you ever, or are you now, taking estrogen or hormone replacement therapy?
Yes No

If yes, what did you take and for how long? _____

Have you ever taken birth control pills? Yes No

If yes, when did you start and how long did you take them? _____

How many times have you been pregnant? _____

How old were you at your first pregnancy? _____

List your age(s) at subsequent pregnancies: _____

Have you ever breast fed? Yes No

If yes, how long did you breast feed? _____

Have you ever taken medication to help you get pregnant? Yes No

If yes, what did you take and for how long? _____

Once this is form is complete, please return it, along with the following Family History Questionnaire to:

**Patricia Rice, C.R.N.P.
Oncology Care Consultants
501 West 7th St., Suite 1A
Frederick, MD 21701**



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FAMILY HISTORY

Please complete this form to the best of your ability. Make sure you include dates and ages at diagnoses. Answer all questions related to each family member. You may use the back of the paper for additional family members and information. If you need any help or have questions regarding the completion of this form, please contact Patricia Rice, C.R.N.P., at (301) 662-8477.

Family History - You, Your Parents, Your Grandparents and Spouse

	First and Last Name & Ethnic Origin	Date of birth	Living?	Any Colon Polyps? If yes, at what age?	If deceased, date and cause of death	Cancer?	Type of Cancer	Age at diagnosis	Other medical problems or surgery	Hospital
Your Mother			Yes No	Yes (Age____) No or unknown		yes no				
Mother's Mother			Yes No	Yes (Age____) No or unknown		yes no				
Mother's Father			Yes No	Yes (Age____) No or unknown		yes no				
Your Father			Yes No	Yes (Age____) No or unknown		yes no				
Father's Mother			Yes No	Yes (Age____) No or unknown		yes no				
Father's Father			Yes No	Yes (Age____) No or unknown		yes no				
Spouse			Yes No	Yes (Age____) No or unknown		yes no				

Family History - Your children

Male	Female	First & Last Name	Date of Birth	Living	Any Colon Polyps? If yes, at what age?	If deceased, date and cause of death	Cancer?	Type of Cancer	Age at diagnosis	Other medical problems or surgery	Hospital
M	F			Yes No	Yes (Age _____), No or unknown		yes no				
M	F			Yes No	Yes (Age _____), No or unknown		yes no				
M	F			Yes No	Yes (Age _____), No or unknown		yes no				
M	F			Yes No	Yes (Age _____), No or unknown		yes no				

Family History - Your brothers and sisters

M	F			Yes No	Yes (Age _____), No or unknown		yes no				
M	F			Yes No	Yes (Age _____), No or unknown		yes no				
M	F			Yes No	Yes (Age _____), No or unknown		yes no				
M	F			Yes No	Yes (Age _____), No or unknown		yes no				

Family History - Aunts and Uncles (Your mother's brothers and sisters)

Male	Female	First & Last Name	Date of Birth	Living?	Any Colon Polyps? If yes, at what age?	If deceased, date and cause of death	Cancer?	Type of Cancer	Age at diagnosis	Other medical problems or surgery	Hospital
M	F			Yes No	Yes (Age ___) No or unknown		yes no				
M	F			Yes No	Yes (Age ___) No or unknown		yes no				
M	F			Yes No	Yes (Age ___) No or unknown		yes no				
M	F			Yes No	Yes (Age ___) No or unknown		yes no				

Aunts and Uncles (Your father's brothers and sisters)

M	F			Yes No	Yes (Age ___) No or unknown		yes no				
M	F			Yes No	Yes (Age ___) No or unknown		yes no				
M	F			Yes No	Yes (Age ___) No or unknown		yes no				
M	F			Yes No	Yes (Age ___) No or unknown		yes no				

Family History - Your nieces, nephews and other family members

Relationship	First & Last Name	Date of Birth	Living?	Any Colon Polyps? If yes, at what age?	If deceased, date and cause of death	Cancer?	Type of Cancer	Age at diagnosis	Other medical problems or surgery	Hospital
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				
			Yes No	Yes (Age ___) No or unknown		Yes No				



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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Physicians Name: _____

Address _____

Phone Number _____ Fax Number: _____

 Patient Name: _____ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

I authorize you to release copies of my medical records to :

Oncology Care Consultants
 Elhamy D. Eskander, M.D., F.A.C.P.
 Mark G. Goldstein, M.D.
 Brian M. O'Connor, M.D.
 Patricia A. Rice, C.R.N.P.
501 West 7th Street, Suite 1A
Frederick MD 21701
Phone: (301) 662-8477
Fax: (301) 662-4293

As required by Maryland law, I give special permission to release any information regarding the following conditions which may or may not be present: **(Please initial on line(s) below to indicate that you grant special permission to release this information to the party above)**

_____ Substance Abuse _____ HIV Information _____ Mental Health

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance thereon, and that there may be a charge for this information.

Reason for request: _____

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____