The Wellness & Aesthetics Medical Center

Vernon F. Williams, M.D.

REGISTRATION FORM					Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Marital status:

Is this your legal name?	If not, what is your legal name?	Email:	Birth date:	Age:	Sex:
◯ Yes ◯ No					◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Chose clinic because/referred to clinic by	◯	Doctor's Name:
(Please choose one option):	◯	Other:

Other family members seen here:

INSURANCE/BILLING INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] to release any information required to process my claims, if any.

Patient/Guardian signature _______________ Date _______________

The Wellness & Aesthetics Medical Center

Vernon F. Williams, M.D.

PERSONAL

Date of Birth:	Age: Sex: Female ___ Male ___	Marital status:

Body Frame (Choose one):

Small ___ Medium ___ Large ___

Blood Type (If known):	Weight (Current): lbs.	
Weight (Lowest): lbs.	Weight (Highest): lbs.	Weight (Ideal): lbs.

Martial Status: Single ___ Married ___ Significant Other ___ Divorced ___ Widowed ___

Do you have any children? Yes ___ No ___ If so, how many?

Do you have any grandchildren? Yes ___ No ___ If so, how many?

Occupation:

How would you rate your current health? Excellent ___ Good ___ Average ___ Fair ___ Poor ___

What are your Age Management Medical Goals?

(Please provide a brief summary below)

PERSONAL HEALTH HISTORY

When was the last time you went to the doctor for a general check up or an illness?

Within the past 12 months, how many times did you see a medical doctor about your health?

Which of the following do you do on a regular basis: ***Check all that apply.***

Annual dental check ups ___ Annual teeth cleaning ___ Brush your teeth at least twice a day
Use dental floss on a daily basis ___ None of the above ___

Comparing your health to others of your age, how would you rate your health?
Excellent ___ Good ___ Average ___ Fair ___ Poor ___

During the past year, how many days did you miss form work, or have your regular activities curtailed, due to illness?

____

____

In the past 12 months, how many days were you in the hospital? _______________________

Do you have an annual rectal exam? Yes ____ No ____

Do you have an annual examination for blood in your stool? Yes ___ No ___

Please review the list of conditions and check the column(s) that most applies to you and your family history.
Leave blank any condition(s) you wish to discuss privately with your Physician.

Condition(s)	Not applicable	Myself	Sibling	Parents Mother	Father	Grandparents Maternal	Paternal
Heart Disease							
Cancer							
Diabetes							
High Blood Pressure							
Arthritis							
Liver Disease: (Hepatitis, Cirrhosis, etc.)							
Mental Health Issues: (Depression, Anxiety, Psychotic Disorders, etc.)							

PERSONAL HEALTH HISTORY CONT'D

Condition(s)	Not applicable	Myself	Sibling	Parents		Grandparents	
				Mother	Father	Maternal	Paternal
Autoimmune Disease: (Lupus, Rheumatoid Arthritis, etc.)							
Endocrine Gland Disorders: (Thyroid, Adrenal, Pituitary)							
Neurological Disorders: (Stroke, Alzheimer's, Parkinson's, etc.)							
Lung Disease: (Asthma, Emphysema, Bronchitis, etc.)							
Abnormal EKG:							
Kidney Disease: (Stones, Infections, Cysts, etc.)							
Stomach/Esophagus: (Reflux, Stricture, Ulcers, etc.)							
Bowel Disease: (Malabsorption, Lactose intolerance, Crohn's, Colitis, IBS, etc.)							
Bladder Disease							
Substance Abuse (Alcoholism, Prescription Drugs, Recreational Drugs, Tobacco, etc.)							
Weight Control Problems							
Osteoporosis							
Migraine Headaches							
Anemia							
HIV/ AIDS							
Allergies							
Memory Problems							
Sleep Apnea/ Snoring							

PERSONAL HEALTH HISTORY CONT'D

Please list any diagnostic procedures you have had. Provide the approximate date, reason for the procedure, and result.

____

____

Please list any surgical procedures you have had, including plastic surgery, along with approximate the date.

____

____

Have you ever had a blood transfusion? Yes ___ No ___ If so, please list the approximate date(s) and reason(s).

____

____

Please indicate if you are currently receiving any of the following:

Radiation Therapy Condition: ____

Chemotherapy Condition: ____

Please provide the date and length of exposure, if any, to the environmental risks listed below.

Exposure	Date(s)	Length of Exposure
Asbestos:		
Coal Dust:		
Chemicals:		
Sun/Tanning:		
Fumes/Gasses:		
Radon Testing:		
X-ray Treatments:		
Other:		

Please describe any current usage of recreational drugs, if any.

____

____

____

____

____

PERSONAL HEALTH HISTORY CONT'D

Are you allergic to any drugs? If yes, please list the drug(s) and describe the reaction.

____

____

Please list all medications including dosage and frequency (prescription and/or over-the-counter) you currently take and the condition for which it is taken.

Medication	Condition	Dosage	Times Per Day

Please list all supplements including dosage and frequency (i.e. vitamins, herbs, nutritional supplements) you currently take and the condition for which it is taken. An option is to copy the labels and forward them along with your completed questionnaire.

Supplement	Condition	Dosage	Times Per Day

METABOLIC ASSESSMENT FORM

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I: Colon

Lower abdominal pain relieved by passing stool/gas 0 1 2 3
Feeling that bowels do not empty completely 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Coated tongue, "fuzzy" debris on tongue 0 1 2 3
Pass large amount of foul-smelling gas 0 1 2 3
More than 3 bowel movements daily 0 1 2 3
Hard, dry, small stool 0 1 2 3
Use laxatives daily 0 1 2 3
Diarrhea 0 1 2 3

Category II: Intestinal Barrier

Increasing frequency of food reactions 0 1 2 3
Unpredictable food reactions 0 1 2 3
Aches, pains, & swelling throughout body 0 1 2 3
Unpredictable abdominal swelling 0 1 2 3
Frequent bloating and distention after eating 0 1 2 3

Category III: Chemical Tolerance

Intolerance to smells 0 1 2 3
Intolerance to jewelry 0 1 2 3
Intolerance to shampoo, lotion, detergents, etc. 0 1 2 3
Multiple smell and chemical sensitivities 0 1 2 3
Constant skin outbreaks 0 1 2 3

Category IV: Stomach

Excessive belching, burping, or bloating 0 1 2 3
Gas immediately following meal 0 1 2 3
Offensive breath 0 1 2 3
Difficult bowel movements 0 1 2 3
Sense of fullness during & after meals 0 1 2 3
Difficulty digesting proteins & meats 0 1 2 3
Undigested foods found in stool 0 1 2 3

Category V: Stomach

Stomach pain, burning, or aching after eating 0 1 2 3
Use of antacids 0 1 2 3
Feel hungry an hour or two after eating 0 1 2 3
Heartburn when lying down/ bending forward 0 1 2 3
Temporary relief by using antacids, food, milk 0 1 2 3
Digestive problems subside w/rest & relaxation 0 1 2 3
Heartburn due to spicy foods, chocolate, citrus…
Peppers, alcohol, caffeine, etc. 0 1 2 3

Category VI: Pancreas

Difficulty digesting roughage and fiber 0 1 2 3
Indigestion & fullness last 2-4hrs after eating 0 1 2 3
Pain, tenderness, soreness left side under ribcage 0 1 2 3
Excessive passage of gas 0 1 2 3
Nausea/Vomiting 0 1 2 3
Stool undigested, foul smelling, mucus like 0 1 2 3
Frequent loss of appetite 0 1 2 3

Category VII: Small Intestines

Abdominal distention after consuming:
Fibers, starches, and sugar 0 1 2 3
Abdominal distention after certain probiotic
Or natural supplements 0 1 2 3
Decreased gastrointestinal motility, constipation 0 1 2 3
Increased gastrointestinal motility, constipation 0 1 2 3
Alternating constipation and diarrhea 0 1 2 3
Suspicion of nutritional malabsorption 0 1 2 3
Frequent use of antacid medication 0 1 2 3
Have you been diagnosed with:
Celiac Disease, Irritable Bowel Syndrome,
Diverticulosis, Leaky Gut Syndrome? YES / NO

METABOLIC ASSESSMENT FORM

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category VIII: Gall Bladder

Greasy or high-fat foods cause distress 0 1 2 3
Lower bowel gas and/or bloating,
several hours after eating 0 1 2 3
Bitter metallic taste in mouth,
especially in the mornings 0 1 2 3
Burpy, fishy taste after consuming fish oils 0 1 2 3
Unexplained itchy skin 0 1 2 3
Yellowish cast to eyes 0 1 2 3
Stool color alternated from clay to colored to brown 0 1 2 3
Reddened skin, especially palms 0 1 2 3
Dry of flaky skin and/or hair 0 1 2 3
History of gallbladder attacks or stones 0 1 2 3
Have you ever had your gallbladder removed? YES / NO

Category IX: Liver Detoxification

Acne and unhealthy skin 0 1 2 3
Excessive hair loss 0 1 2 3
Overall sense of bloating 0 1 2 3
Bodily swelling for no reason 0 1 2 3
Hormone imbalances 0 1 2 3
Weight gain 0 1 2 3
Poor Bowel Function 0 1 2 3
Excessively foul-smelling sweat 0 1 2 3

Category X: Sugar/Hypoglycemia

Crave sweets during the day 0 1 2 3
Irritable if meals are missed 0 1 2 3
Depend on coffee to keep going/ get started 0 1 2 3
Get light-headed if meals are missed 0 1 2 3
Eating relieves fatigue 0 1 2 3
Agitated, easily-upset, nervous 0 1 2 3
Feel shaky, jittery, or have tremors 0 1 2 3
Poor memory, forgetful between meals 0 1 2 3
Blurred Vision 0 1 2 3

Category XI: Diabetes/ Insulin Resistance

Fatigue after meals 0 1 2 3
Crave sweets during the day 0 1 2 3
Eating sweets doesn't relieve cravings for sugar 0 1 2 3
Must have sweets after meals 0 1 2 3
Waist girth is equal or larger than hip girth 0 1 2 3
Frequent urination 0 1 2 3
Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category XII: Adrenal Fatigue

Cannot stay asleep 0 1 2 3
Crave Salt 0 1 2 3
Slow starter in the morning 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3
Headaches with exertion or stress 0 1 2 3
Weak nails 0 1 2 3

Category XIII: Adrenal Stress

Cannot fall asleep 0 1 2 3
Perspire easily 0 1 2 3
Under high amount of stress 0 1 2 3
Weight gain under stress 0 1 2 3
Wake up tired after 6 or more hours of sleep 0 1 2 3
Excessive perspiration or perspiration with little
Or no activity 0 1 2 3

METABOLIC ASSESSMENT FORM

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category XIV: Electrolyte and PH Balance

Edema and swelling in ankles and wrists 0 1 2 3
Muscle cramping 0 1 2 3
Poor muscle endurance 0 1 2 3
Frequent urination 0 1 2 3
Crave Salt 0 1 2 3
Frequent thirst 0 1 2 3
Abnormal sweating from minimal activity 0 1 2 3
Alteration in bowl regularity 0 1 2 3
Inability to hold breath for long periods 0 1 2 3
Shallow, rapid breathing 0 1 2 3

Category XV: Hypothyroidism

Tired/sluggish 0 1 2 3
Feel cold- hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increase in weight even with low-calorie diet 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression/ lack of motivation 0 1 2 3
Morning headaches that wear off as the day progresses 0 1 2 3
Outer third of eyebrow thins 0 1 2 3
Thinning of hair on scalp, face, or genitals 0 1 2 3
Mental sluggishness 0 1 2 3

Category XVI: Hyperthyroidism

Heart palpitation 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervous and emotional 0 1 2 3
Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XVII (MALES only): Prostate

Urination difficulty or dribbling 0 1 2 3
Frequent urination 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel emptying 0 1 2 3
Leg twitching at night 0 1 2 3

Category XVIII (MALES only): Andropause/ED

Decreased libido 0 1 2 3
Decreased number or spontaneous morning erections 0 1 2 3
Decreased fullness of erections 0 1 2 3
Difficulty maintaining morning erections 0 1 2 3
Spells of mental fatigue 0 1 2 3
Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decreased physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips 0 1 2 3
Sweating Attacks 0 1 2 3
More emotional than in the past 0 1 2 3

Category XIX (Menstruating FEMALES only):

Perimenopausal 0 1 2 3
Alternating menstrual lengths 0 1 2 3
Extended menstrual cycle lengths (32+ days) 0 1 2 3
Shortened menstrual cycle lengths (24 days/ less) 0 1 2 3
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvis pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/ thinning 0 1 2 3

Category XX (Menopausal FEMALES only):

How many years have you been menopausal ____yrs
Since menopause, do you have uterine bleeding? YES / NO
Hot flashes 0 1 2 3
Mental fogginess 0 1 2 3
Disinterest in sex 0 1 2 3
Mood Swings 0 1 2 3
Depression 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breasts 0 1 2 3
Facial hair growth 0 1 2 3
Increased vaginal pain, dryness, itching 0 1 2 3

NEUROTRANSMITTERS ASSESSMENT FORM

Please check the circles/boxes which correspond to your circumstance.

Do you suffer from:

- **(These neurotransmitters may be involved)**

- Poor Sleep
  - Serotonin, Taurine, GABA Glutamine, Histamine, PEA, Norepinephrine, Epinephrine
- Fatigue
  - Glutamate, Histamine, Norepinephrine, Epinephrine
- Anxiousness
  - Taurine, GABA, Glycine, Glutamate, PEA, Norepinephrine, Epinephrine
- Low Mood
  - Serotonin, Glycine, Glutamate, PEA, Norepinephrine, Dopamine,
- Attention Difficulties
  - PEA, Dopamine, Norepinephrine
- Excess Energy
  - Norepinephrine, Epinephrine, PEA
- Cravings
  - Serotonin, Glutamate, Dopamine
- Intestinal Complaints
  - Serotonin, Dopamine
- Poor Cognitive Function
  - PEA, Dopamine, Norepinephrine, Epinephrine
- Weight Problems
  - Serotonin, Epinephrine
- Excess Stress
  - Serotonin, Glycine, Norepinephrine, Epinephrine
- Headaches
  - Serotonin, Histamine
- Immune Issues
  - Serotonin, Glycine, Glutamate, Histamine, Norepinephrine

How often in a typical week do you do any of the following?

	Not at all	Few days	More than half the days	Nearly every day
Take more than 30 min. to fall asleep at night				
Wake up frequently during the night				
Take OTC sleep aids to help you sleep at night				
Find it hard to carry on detailed conversations				
Have difficulty staying alert while driving				
Feel drowsy during the day or during peak activities				
Awaken feeling groggy and lethargic				
Suffer from any: mild depression, stress, or low self-esteem				
our grades or productivity are slipping				

GENETIC FITNESS PROFILE

Please check those questions which you'd like answered.

The Science of You

By analyzing your genetic markers, the Pathway Fit genetic and lifestyle report is designed to help give you the power to understand your metabolism and response to exercise, which may help you establish and maintain a healthier lifestyle.

FIND ANSWERS

- Would you like to know what type of diet may be best for you?
- Have you ever wondered why you can't say "no" to certain foods?
- Is snacking in your genes?
- What vitamins are you likely to be deficient in?
- Would you like to know what types of exercise might be most effective for you?

Individualized Nutrition May Help You:

- ✓ Achieve your right weight
- ✓ Increase your mental and physical performance
- ✓ Optimize your metabolism and gain more energy
- ✓ Live better and do more

TOXICITY PROFILE

Please circle (Yes / No) the appropriate response. More than five "yes" means that you may have an increased risk of an exposure or toxic burden.

1) Do you eat fast-food meals at least three times per week? Y / N
2) Are you overweight? Y / N
3) Do you tend to overeat? Y / N
4) Do you consume "sugar free" food sweetened with aspartame or other sweeteners? Y / N
5) Do you regularly consume foods that contain MSG? Y / N
6) Do you eat foods, especially packaged foods, that contain artificial colors? Y / N
7) Do you eat "refined carbs" at any time during the day? Y / N
8) Do you eat nonorganic produce? Y / N
9) Do you eat fewer than 7-9 servings of fresh fruit and vegetables per day? Y / N
10) Do you drink sodas every day or several times per week? Y / N
11) Do you drink non-organic coffee? Y / N
12) Do you drink more than two cups of coffee per day? Y / N
13) Do you drink less than 8 glasses, or 2 quarts, of water per day? Y / N
14) Do you cook or reheat food in plastic containers? Y / N
15) Do you microwave food? Y / N
16) Are you presently using prescription drugs? Y / N
17) Have you ever experienced an allergic reaction/side effects to any medications? Y / N
18) Do you have strong negative reactions to caffeine? Y / N
19) Do you currently smoke/use tobacco products? Y / N
20) Have you smoked in the past 10 years? Y / N
21) Have you ever used recreational drugs? Y / N
22) Do you experience brain fog or drowsiness? Y / N
23) Do you develop symptoms on exposure to fragrances, exhaust fumes, odors? Y / N
24) Do you feel ill after consuming even small amounts of alcohol? Y / N
25) Have you ever been exposed to harmful chemicals? Y / N
26) Have you ever been exposed to mold in your house/work? Y / N
27) Have you ever had chemical dependence? Y / N
28) Have you ever had asthma? Y / N
29) Have you ever had chronic fatigue or fibromyalgia? Y / N
30) Do you have allergies to environmental substances/food? Y / N
31) Do you live in a house that is over 25 years old? Y / N
32) Have you had recent remodeling in your house? Y / N
33) Did symptoms develop after a move to a new house, workplace, remodeling? Y / N

TOTAL YES ANSWERS: ________

Additional Questions

If you have fillings in your teeth, what material are they? ________________________________

Have you removed or replaced any fillings in the past? Y / N

ALLERGY ASSESSMENT

Please circle the number according to severity: 0 = NONE, 2 = MILD, 4 = SEVERE.

Common Symptoms

Nasal Congestion 0 1 2 3 4
Fatigue 0 1 2 3 4
Watery, red, itchy eyes 0 1 2 3 4
Frequent sinus or ear infection 0 1 2 3 4
Sneezing 0 1 2 3 4
Frequent colds or sore throat 0 1 2 3 4
Wheezing 0 1 2 3 4
Poor Memory or concentration 0 1 2 3 4
Asthma 0 1 2 3 4

Cough 0 1 2 3 4
Hyperactivity 0 1 2 3 4
Itching 0 1 2 3 4
Abdominal gas or cramping 0 1 2 3 4
Eczema 0 1 2 3 4
Arthritis or muscle aching 0 1 2 3 4
Hives 0 1 2 3 4
Trouble breathing while sleeping 0 1 2 3 4
Headaches 0 1 2 3 4

SYMPTOM SCORE: _______________ List any other symptoms: _______________________________________

1. Do you experience sensitivity to any particular foods? ( ) Yes ( ) No
   If yes, what are your symptoms? ____
2. Do you have a history of allergies? ( ) Yes ( ) No
   If yes, please answer the following:
   How long have you experienced symptoms: ____
   What season(s) do your allergies flare up? ( ) Spring ( ) Summer ( ) Fall ( ) Winter ( )All Year
   How would you describe the frequency of your symptoms? ( ) Constant ( ) Intermittent
3. Have you been tested for allergies? ( ) Yes ( ) No
   If yes, have you ever received allergy shots as a form of therapy? ( ) Yes ( ) No
   Have you ever taken prescription medications to treat allergy symptoms? ( ) Yes ( ) No
   If yes, which medication and for how long did you take the medications?
   ____
   Does any medication relieve your allergy symptoms? ( ) Yes ( ) No
4. Do you have pets at home? ( ) Yes ( ) No Do they cause symptoms? ___________________________
5. Are you exposed to fumes or dust at work? ( ) Yes ( ) No
6. Do you Smoke? ( ) Yes ( ) No How Often? ____________ Do you work in smoky environment? Y / N
7. Does anyone in your family have allergies or asthma? ( ) Yes ( ) No
8. Have you ever been diagnosed with asthma? ( ) Yes ( ) No Age Diagnosed: ____ Severity: __________

____

Do you suffer from uncontrolled asthma or reduced lung function? ( ) Yes ( ) No

Have you ever had a severe allergic reaction? ( ) Yes ( ) No

Have you ever been hospitalized due to allergies or asthma? ( ) Yes ( ) No

Taking Beta Blockers to treat heart disease? ( ) Yes ( ) No Name of Medication: _______________________

(If you answered YES to any of the questions in bold, you will be asked to see the clinician as allergy testing may be contraindicated.)

LYME DISEASE ASSESSMENT

Please mark off the boxes according to the symptoms experienced.

SYMPTOMS OF LYME DISEASE:

Fatigue		Swollen Lymph Nodes	
Headaches		Swelling	
Irritability		Neck Stiffness	
Depression		Muscle Pain	
Focus & Memory Issues		Joint Pain	
Sleep Issues		Palpitations & Chest Pain	
Facial Paralysis		Numbness & Tingling in Limbs	
Fever		Lightheadedness & Dizziness	

Please circle Yes / No in the following Self-Test

- ✓ Have you had recent exposure to tick-friendly environments: tall grasses, wooded areas, etc.? Y / N
- ✓ Have you experienced a bull's eye rash recently? Y / N
- ✓ Are you experiencing recurrent fatigue or low energy? Y / N
- ✓ Have you experienced joint pain or muscle aches recently? Y / N
- ✓ Are you experiencing brain fog, recurrent headaches, or anxiety? Y / N
- ✓ Have you been suffering from insomnia? Y / N
- ✓ Have you received a negative Lyme Antibody test result in the past? Y / N

HEREDITARY CANCER RISK ASSESSMENT

Please mark "Yes" or "No" below if you, or a close blood relative, has a history of the following cancers. If "Yes", please indicate your relationship, and age diagnosed. Include both your mother's and father's sides of the family, and list each relative separately.

Personal/Family History	Circle Yes / No	You, Age	Children, Siblings, Age	Mother's Side Relationship, Age	Father's Side Relationship, Age
Breast Cancer at age 45 or younger	Y / N				
2 or more separate breast cancers in one person, first at 50 or younger	Y / N				
2 relatives w/breast cancer, one age 50 or younger	Y / N				
Ovarian cancer, any age	Y / N				
Triple negative breast cancer, age 60 or younger	Y / N				
3 or more on the same side of family at any age: breast, pancreatic, aggressive prostate	Y / N				
Male breast cancer at any age	Y / N				
Jewish ancestry with breast, ovarian/ pancreatic cancer any age	Y / N				
Colon, rectal or uterine (endometrial) cancer at 50 or younger	Y / N				
2 individuals on same side (myself included): 1 with colorectal or uterine at any age; PLUS 1 diagnosed at 50 or younger with a Lynch-associated cancer*	Y / N				
3 or more individuals on same side (myself included) with a LYNCH-associated cancer* at any age, one of which is a colorectal or uterine (endometrial) cancer	Y / N				
10 or more pre-cancerous colon polyps found in 1 person through their lifetime	Y / N				
Other cancers (melanoma, thyroid, etc.) Please list site of cancer, relative and age	Y / N				

**Lynch-associated cancers include: colon, rectal, uterine (endometrial), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary (liver), sebaceous (skin gland)*

Ashkenazi Jewish: Y / N

Have you or a relative ever had genetic testing for BRCA1/2, LYNCH Syndrome, Polyposis, or other hereditary cancer syndrome(s)? Y / N

If yes: Who had testing, when, and if known, where? ____

If yes: Specific mutation known to family: Gene ______________________________ Mutation ___________________________________

Gleason Score (for prostate testing only): ____