CANCERINTERCEPT™ MONITOR

Clinical History Questionnaire

PATHWAY GENOMICS®

A CAP and CLIA Accredited Laboratory | 4755 Nexus Center Drive, San Diego, CA 92121 | 877.505.7374 | www.pathway.com | clientservices@pathway.com

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

PERSONAL HISTORY:

☐ No personal history of cancer

If you have no personal history of cancer, **STOP** and fill out the CancerIntercept™ Detect clinical history form. This test is only for individuals who have been diagnosed with cancer.

Why are you ordering this test?

☐ New cancer diagnosis
☐ Current treatment monitoring
☐ Past cancer diagnosis
☐ Cancer metastasis
☐ Cancer recurrence

Type of Cancer	Age diagnosed	Tumor Status at Diagnosis		Current Tumor Status	
		Stage (TNM)	Grading (G)	Stage (TNM)	Grading (G)
Breast					
Ovarian					
Colorectal					
Melanoma					
Lung					
Other*: _____					

**Examples: endometrial, pancreatic, renal, gastric, sarcoma, aggressive prostate, etc.*

PATHOLOGY RESULTS:

☐ No pathology has been done at this time

HORMONAL/PROTEIN STATUS

☐ ER+ ☐ PR+ ☐ HER2+ ☐ KI67+ % POSITIVE_____
☐ ER- ☐ PR- ☐ HER2- ☐ KI67-

Previous tumor genotyping**:_____

Other immunohistochemical (IHC) staining **:_____

Other genetic testing results**:_____
Including cytogenetic and FISH analysis results.

Other histology results**: _____
** If testing has been performed previously, please attach a copy of the report

TNM Classifications
T - Primary Tumor (TX-T4)
N - Lymph Nodes (NX-N3)
M - Metastasis (M0 or M1)

Tumor Grading
GX - Grade cannot be assessed
G1 - Well differentiated
G2 - Moderately differentiated
G3 Poorly differentiated
G4 - Undifferentiated

HAS THE PATIENT PREVIOUSLY HAD HEREDITARY CANCER TESTING?:

☐ yes (attach results) ☐ no (skip this section)

☐ Hereditary Breast and Ovarian Cancer gene testing (i.e.: *BRCA1/2* gene testing) *Result: _____

☐ Lynch Syndrome gene testing (*MLH1, MSH2, MSH6, PMS2, EPCAM*) *Result:_____

☐ Other hereditary cancer testing: Type: _____ *Result:_____

*Please attach a copy of test results to this form. If results are from a family member, please indicate relationship to patient (i.e.: sister, maternal aunt, paternal grandfather).

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EXPLAIN THE PATIENT'S EXPOSURE HISTORY BELOW: (MARK ALL THAT APPLY)

☐ None

Daily Exposures

☐ Alcohol
Drinks/day: _____

☐ Cigarette smoking (tobacco use)
Packs/day: _____

☐ Radiation (radon, x-rays, gamma rays)
Length of exposure: _____

☐ Ultraviolet exposure (tanning beds, sun exposure, sunburns)
Rate your exposure (high, medium, low):
_____

☐ Consume (eat) red meat
Meals per week: _____

☐ Diesel fuel

☐ Secondhand smoke
(i.e. living with a smoker)

☐ Genital use of talcum powder

Toxin and Work Exposures

☐ Arsenic # of years: _____

☐ Asbestos # of years: _____

☐ Chromium # of years: _____

☐ Nickel # of years: _____

☐ Silica dust # of years: _____

☐ Tar and soot # of years: _____

☐ Paint/solvent/chemicals # of years: _____

Other Exposure Information: _____

_____

_____

Occupation: _____

Examples: Coal miner, steel mill worker, flight attendant, pilot, doctor, accountant, researcher, etc.

PERSONAL MEDICAL INFORMATION: (MARK ALL THAT APPLY)

Date of last mammogram: _____ Result: _____ ☐ N/A

Date of last colonoscopy: _____ Result: _____ ☐ N/A

Total number of pregnancies: _____ Number of children (live births): _____

Age at time of first birth: _____ Age at menarche (first menstrual cycle) _____ Age at menopause: _____

Mark all conditions that apply to you:

☐ Acute and chronic pancreatitis
☐ Asthma
☐ Chronic hepatitis B
☐ Chronic hepatitis C
☐ Chronic obstructive pulmonary disease (COPD)
☐ Cirrhosis
☐ Colon/ rectal polyps
☐ Diabetes
☐ Endometriosis
☐ HIV
☐ Hormone use (i.e. fertility drugs, hormone replacement therapy)
☐ Idiopathic pulmonary fibrosis
☐ Infectious agents
☐ Inflammatory bowel disease (ulcerative colitis or Crohn's)
☐ Liver disease
☐ Obesity
☐ Pelvic inflammatory disease

Other conditions: _____

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TREATMENT INFORMATION: (MARK ALL THAT APPLY) ☐ This patient has not received any treatment thus far

☐ Hormone Therapy: _____

Date(s): _____ Cycle(s)/duration: _____ Last Treatment: _____

☐ Targeted Therapy: _____

Date(s): _____ Cycle(s)/duration: _____ Last Treatment: _____

☐ Chemotherapy: _____

Date(s): _____ Cycle(s)/duration: _____ Last Treatment: _____

☐ Radiation Therapy: _____

Date(s): _____ Cycle(s)/duration: _____ Last Treatment: _____

☐ Radiation Therapy: _____

Date(s): _____ Cycle(s)/duration: _____ Last Treatment: _____

☐ Other (type): _____

☐ Surgical resection (provide any relevant information): _____

☐ Date/ type of patient's last: Blood transfusion | stem cell transplant _____

Other medications/ supplements (type and dose): _____

Other relevant medical history: _____

_____

_____

FAMILY HISTORY: ☐ No Family History Available

Maternal	Paternal	Relationship	Cancer type or Condition	Age of Diagnosis
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			
☐	☐			

▶ Patient Signature: _____ ▶ Physician Signature: _____ Date: _____

Print: _____ Print: _____