# General Patient Information

**Hormonal History:**

1. How old were you when you started your period? _____

2. How many years did you take the oral contraceptive pill? _____

3.Have you had IVF? Y / N If Yes, How many cycles ?_____

4. How many children do you have? _____ Did you breast feed? Y / N

5. Are you pre / peri / post menopausal?( circle correct answer)

6. At what age did you go through the menopause? _____

7. Have you ever taken Hormone Replacement? _____ For how long? _____

Are you still taking hormone replacement?_____How long ago did you stop? _____

8. Do you have a family history of breast or ovarian cancer? Y/N If Yes, please list your family

members with the ages they developed the cancers_____

_____

**General Health:**

Do you have any known medical problems (please list)? _____

_____

Are you taking any medication (please list name and dose)? _____

_____

Are you taking any blood thinners ( including aspirin, fish oil, krill oil, ginko biloba)?_____

_____

Have you ever had an operation? (please state when and what type) _____

_____

Are you allergic to anything? _____

Are you a smoker? Y / N Have you ever been a smoker/when did you quit? _____