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| Packet received: \_\_\_\_\_\_\_\_\_\_  Appointment: \_\_\_\_\_\_\_\_\_\_ |



# HEREDITARY CANCER

# FAMILY HISTORY QUESTIONNAIRE

Thank you for your interest in our cancer genetic counseling and testing services! To better understand your personal and family risk factors, please take some time to complete this questionnaire. Although it can take some time, this questionnaire is designed to gather important information about your personal and family histories. By completing it thoroughly, you help us determine if you or other family members may be at increased risk to develop cancer. We look forward to providing you with the most accurate risk assessment, comprehensive genetic counseling, and appropriate genetic testing options. **We will schedule you for a consultation as soon as we receive this completed questionnaire back from you\*.** If you have any questions, please call us at 406-444-1016.

## Clinic Address/FAX:

Shodair Children’s Hospital

Department of Medical Genetics

2755 Colonial Drive

Helena, MT 59601

Fax: 406-444-1064

\*PLEASE NOTE: If one of your family members has already had cancer genetic counseling and/or genetic testing, please contact us. You may not need to complete this entire questionnaire.

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**INSTRUCTIONS FOR COMPLETING THE FAMILY HISTORY QUESTIONNAIRE:**

**√** Please fill in all of the columns as completely as possible.

**√** Please record ALL relatives, **EVEN IF THEY DO/DID NOT HAVE CANCER.**

**√** If you have no relatives in any of the categories listed, please put an ‘X’ in the box for ‘NONE’.

**√** Please give as much information as possible about dates of birth and death or **current ages**/ages at death. *Approximate ages are okay (ex: 70s).*

**√** Write UNK (unknown) if you do not know, or NA (not applicable) if information requested does not apply.

**PERSONAL INFORMATION**

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your biological sex: \_\_\_\_\_ Male \_\_\_\_\_Female

Your gender (optional): \_\_\_\_\_\_ Man \_\_\_\_\_ Woman \_\_\_\_\_ Other (please describe)

Telephone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**To preserve your privacy, please tell us may we contact you:**

By phone at home? Yes No By cell phone? Yes No

By phone at work? Yes No By mail? Yes No

By e-mail? (if yes, enter here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ancestry/race** (check as many as apply)

\_\_\_\_ White/Caucasian \_\_\_\_ Hispanic/Latina/Latino \_\_\_\_ Black/African American

\_\_\_\_ Asian/Asian-American \_\_\_\_ American Indian/Alaskan Native

\_\_\_\_ Multiracial (specify) \_\_\_\_ Other (specify)

If you know, please list the specific countries where your distant ancestors originated.

Mother’s side: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s side: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Because some health conditions occur more frequently in Jewish populations, please answer:

Is your father Ashkenazi Jewish? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Unsure

Is your mother Ashkenazi Jewish? \_\_\_\_Yes \_\_\_\_No \_\_\_\_Unsure

**LIFESTYLE AND SOCIAL HISTORY**

Do you smoke? \_\_\_\_Yes \_\_\_\_No

If yes, how many cigarettes per day? \_\_\_\_

Do you drink alcohol? \_\_\_\_Yes \_\_\_\_No

If yes, how many drinks per week? \_\_\_\_

What do you do for a living? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to large amounts of chemicals? \_\_\_\_Yes \_\_\_\_No

If yes, what and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CANCER RISK ASSESSMENT**

Number of colonoscopies or sigmoidocopies you have had? \_\_\_\_

Were any polyps detected? \_\_\_\_Yes \_\_\_\_No \_\_\_Unsure

If so, how many polyps were detected? \_\_\_\_

If so, age that polyps were detected? \_\_\_\_

Do you do any other cancer screenings (i.e. prostate, self-breast exam, skin check)?\_\_\_Yes\_\_\_No

If yes, what type(s) and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females only:**

Age at your first menstrual period? \_\_\_\_

Age at menopause? \_\_\_\_

Have you had mammogram(s)? \_\_\_\_

If yes, age at first mammogram \_\_\_\_

Frequency of mammograms (ex. yearly, sporadically, etc.):\_\_\_\_\_\_\_\_\_\_\_

Date of last mammogram and result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of breast biopsies you have had ? \_\_\_\_

Were any abnormal? \_\_\_\_Yes \_\_\_\_No \_\_\_Unsure

If abnormal, do you recall the result? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first childbirth? \_\_\_\_

How many years on oral birth control pills? \_\_\_\_

How many years of hormone replacement therapy? \_\_\_\_

Have you had your uterus removed? (hysterectomy) \_\_\_\_Yes \_\_\_\_No

Have you had your ovaries removed? \_\_\_\_Yes \_\_\_\_No

**IMMEDIATE FAMILY**

#### PLEASE LIST EVERY RELATIVE REQUESTED

Please write “UNK” if you don’t know or can’t get the answer.

Please write “NA” if the column doesn’t apply. Thank you.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | **FULL NAME** | **Living?** | **Current Age or**  **Age at death** | **Gender** | **Type of Cancer(s)/ Tumor(s)/ Polyps** | **Age Cancer(s)**  **found** | **Other Hereditary or Medical conditions** |
| you |  | yes  no |  | female  male |  |  |  |
| spouse/partner |  | yes  no |  | female  male |  |  |  |
| children (if your children have different parents please write the parent’s name in brackets)  None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
| your mother |  | yes  no |  | female  male |  |  |  |
| your father |  | yes  no |  | female  male |  |  |  |
| your brothers and sisters (if they are half siblings please indicate the shared parent in brackets)  None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | **FULL NAME** | **Living?** | **Current Age or**  **Age at death** | **Gender** | **Type of Cancer(s)/ Tumor(s)/ Polyps** | **Age Cancer(s)**  **found** | **Other Hereditary or Medical conditions** |
| nieces and nephews (please write the name of your brother or sister who is the parent in brackets)  None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
| grandchildren (please write the name of your child who is the parent in brackets)  None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |

# FATHER’S SIDE OF FAMILY

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | **FULL NAME** | **Living?** | **Current Age or**  **Age at death** | **Gender** | **Type of Cancer(s)/ Tumor(s)/ Polyps** | **Age Cancer(s)**  **found** | **Other Hereditary or Medical conditions** |
| grandmother |  | yes  no |  | female  male |  |  |  |
| grandfather |  | yes  no |  | female  male |  |  |  |
| your aunts and uncles (father’s siblings) None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
| your cousins (please write the name of your aunt or uncle who is the parent in brackets)  None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |

# MOTHER’S SIDE OF FAMILY

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family Member** | **FULL NAME** | **Living?** | **Current Age or**  **Age at death** | **Gender** | **Type of Cancer(s)/ Tumor(s)/ Polyps** | **Age Cancer(s)**  **found** | **Other Hereditary or Medical conditions** |
| grandmother |  | yes  no |  | female  male |  |  |  |
| grandfather |  | yes  no |  | female  male |  |  |  |
| your aunts and uncles (mother’s siblings) None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
| your cousins (please write the name of your aunt or uncle who is the parent in brackets)  None |  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |
|  | yes  no |  | female  male |  |  |  |