***G**enetic **R**isk **E**valuation **A**nd **T**esting Program*

Personal and Family History Questionnaire

Name: ______________________________ Date: ______________________________

Date of Birth:__________________________

Address:______________________________ City:______________________________

State:______________________________ Zip:______________________________

Home Phone:__________________________ Work Phone:__________________________

Cell Phone:__________________________ Occupation: __________________________

Gender: Female / Male

Texas Oncology Physician:____________________ Marital Status:__________________________

Referring Healthcare Provider:________________ Primary Care Physician:____________________

Race: ____

Your Mother's family country/countries of origin (Prior to USA):______________________________

Your Father's family country/countries of origin (Prior to USA):______________________________

Do you have Central/Eastern European Jewish Ancestry or Ashkenazi Jewish Ancestry on either side of your family? (Please circle selection)

Mother:	Yes	No	Unsure
Father:	Yes	No	Unsure

Please list any genetic testing you or your family members have had, and please obtain a copy of the genetic report prior to your visit:

____
____
____
____

Your appointment has been scheduled for
Date: ______________________________
Time:______________________________
Office: ______________________________

Please complete this form and bring it with you to your appointment.

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Personal and Family History Questionnaire

Your Personal Health History

1. Your weight: ______________(pounds) Your Height:________________
2. Have you ever had cancer? ↑ YES ↑ NO *If YES, please continue below. If NO, skip to next question.*

   Age at diagnosis__________ Stage of cancer, if known: ____

   What type of cancer were you diagnosed with on this date?

   ____

   What treatments did you receive for this cancer? (surgery, radiation, chemotherapy, hormone): __________

   ____

   Have you had any other cancers? ↑ YES ↑ NO

   Please describe: ____

   ____

3. Please list any other genetic conditions, benign or precancerous growths you have had:__________________

   ____

4. Cancer Screening History:

Screening Test	***Date of Most Recent Exam***	***Results of Most Recent Exam***	***Age at first exam?***	***How often do you have this exam?***	***Comments***
Women:					
Self Breast Exams					
Clinical Breast Exams					
Mammograms					
Breast MRI					
PAP Smear					
CA-125					
Transvaginal Ultrasound					
Men:					
Digital Rectal Exam					
PSA Blood Test					
Men and Women:					
Skin Exams					
Colonoscopy					
Sigmoidoscopy					
Upper Endoscopy (EGD)					
Capsule Endoscopy					
ERCP (endoscopic retrograde cholangiopancreatography)					
Barium Enema					
Fecal Occult Stool Test					
Other/Notes:					

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Personal and Family History Questionnaire

5. Have you been diagnosed with Colon Polyps? ↑ YES ↑ NO

   Age at first colon Polyp ________________ Total Number of colon Polyps ___________________________

   Type of Polyp (If known) ____

6. Have you ever smoked? ↑ YES ↑ NO. If Yes, How many packs per day__________ for how long_________

   Do you drink alcohol? ↑ YES ↑ NO. If Yes, How many drinks per week?____________________________

7. For Women:

- At what age did your periods start? _____________ At what age did your periods stop? __________________
- Why did your periods stop? Circle one: Surgical/Cancer treatment/Natural Menopause/Other:___________
- #of pregnancies_______________ #of births______________# of Miscarriage or abortions_______________
- At what age did you have your first child? _______ Did you breast feed for longer than 1 month? ↑ YES ↑ NO
- Complications with pregnancy?_________________________________ C-sections?______________________
- History of abnormal pap smears?↑ YES ↑ NO Age if yes ____
- Have you ever taken hormone replacement therapy (HRT)? ↑ YES ↑ NO If yes:

  Type ____(estrogen or estrogen and progesterone?)

  Year you began HRT: ____________________________ Year you stopped HRT:_________________________

  Have you ever taken oral contraceptives?↑ YES ↑ NO Total # years taken __________________________

  What age did you start taking oral contraceptives? ______________What age did you stop? ____________

- Have you ever had a breast biopsy? ↑ YES ↑ NO # of biopsies_______________________________

  Did your biopsy show any of the following? Check here if Unknown ______

Atypical Hyperplasia	YES	NO	age? _______	Side	L	R
Lobular Carcinoma in Situ (LCIS)	YES	NO	age? _______	Side	L	R
Ductal Carcinoma in Situ (DCIS)	YES	NO	age? _______	Side	L	R
Invasive Cancer	YES	NO	age? _______	Side	L	R

- Have you had a hysterectomy (surgical removal of uterus)?↑ YES ↑ NO

  Why did you have a hysterectomy? _________________________________ How old were you? __________

- Have you had an oophorectomy (surgical removal of ovaries)? ↑ YES ↑ NO

  Were both ovaries removed?↑ Both Ovaries removed ↑ Right ovary removed ↑ Left ovary removed

  Why did you have an oophorectomy? __________________________________How old were you? _________

Personal and Family History Questionnaire

8. Please list any allergies:____

____

9. Please list all your healthcare providers:

Healthcare Provider Name	Specialty

10. Please List other surgeries and year surgery completed:

Surgery	Year of surgery

11. Please list any medical history (such as diabetes, high blood pressure, depression, thyroid disorder)

Condition	Year diagnosed

12. Please list medications:

Medication	Dosage	Frequency

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Genetic Risk Evaluation And Testing Program

Personal and Family History Questionnaire

YOUR FAMILY HEALTH HISTORY

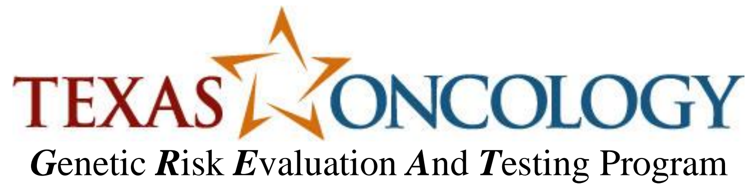
PLEASE LIST ALL FAMILY MEMBERS EVEN THOSE WITHOUT CANCER

Your Children: (Please list all, even those without cancer)

Sex	Name	Age	Age at death	Type of Cancer	Age at diagnosis	Benign or precancerous growth
M / F						
M / F						
M / F						
M / F						
M / F						
M / F						
M / F						

Your Brothers and Sisters: (Please list all, even those without cancer)

Name	Full or Half Sibling?	Sex	Age	Age at death	Type of Cancer	Age at diagnosis	Benign or Precancerous growth
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					
	□ Full Sib □ Maternal ½ Sib □ Paternal ½ Sib	M / F					



Your Nieces and Nephews: (Please list all, even those without cancer)							
Name	**Who is their parent? (Sister Mary)**	**Sex**	**Age**	**Age at Death**	**Type of Cancer**	**Age at Diagnosis**	**Benign or Precancerous Growth**
		M / F					
		M / F					
		M / F					
		M / F					
		M / F					
		M / F					
		M / F					
		M / F					
		M / F					
		M / F					

Your Mother and Maternal Grandparents (Please list all, even those without cancer)						
Relative	**Name**	**Age**	**Age at Death**	**Type of Cancer**	**Age at Diagnosis**	**Benign of precancerous growth**
Mother						
Your Mother's Mother						
Your Mother's Father						

Aunts and Uncles on your MOTHER'S side of the Family (Please list all, even those without cancer)						
Name	**Sex**	**Age**	**Age at Death**	**Type of Cancer**	**Age at Diagnosis**	**Benign or Precancerous Growth**
	M / F					
	M / F					
	M / F					
	M / F					
	M / F					
	M / F					
	M / F					
	M / F					
	M / F					
	M / F					

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Cousins on your MOTHER'S Side of the Family (Please list all, even those without cancer)

Name	Who is their parent? (ex: Uncle Joe)	Sex	Age	Age at Death	Type of Cancer	Age at Diagnosis	Benign or Precancerous Growth

Your Father and Paternal Grandparents (Please list all, even those without cancer)

Relative	Name	Age	Age at Death	Type of Cancer	Age at Diagnosis	Benign or Precancerous Growth
Father						
Your Father's Mother						
Your Father's Father						

Aunts and Uncles on your FATHER'S side of the Family (Please list all, even those without cancer)

Name	Sex	Age	Age at Death	Type of Cancer	Age at Diagnosis	Benign or Precancerous Growth

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Cousins on your FATHER'S Side of the Family (Please list all, even those without cancer)							
Name	**Who is their parent? (ex: Uncle Joe)**	**Sex**	**Age**	**Age at Death**	**Type of Cancer**	**Age at Diagnosis**	**Benign or Precancerous Growth**

Add any additional family members with a history of cancer below or on a separate page if needed.

Please include a copy of genetic test results if possible. If you have death certificates or pathology reports on family members with cancer or pre-cancer, please include with packet.

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***G**enetic **R**isk **E**valuation **A**nd **T**esting Program*

Authorization to Disclose My Genetic Consultation and Genetic Test Results

Patient Name:____ Date of Birth:______________

I Authorize Texas Oncology to disclose genetic consultation notes and genetic test results to the following physicians, or persons:

1. ____

2. ____

3.____

4.____

This Authorization ends one year following the date at which it is signed unless otherwise noted here: ____

____ ________________________________

Patient or Legally authorized individual signature Date

____ ________________________________

Printed name if signed on behalf of the patient Relationship (Guardian, parent, etc)