



Personal and Family History of Cancer

Today's Date: _____

Patient Name: _____
Last First Middle or Maiden

Date of Birth: _____

Please read this information carefully before completing the attached family history questionnaire.

We are interested in learning as much as possible about any history of cancer in your family. Information that is necessary when assessing a family history of cancer includes:

- ☆ **Who:** Which relatives have had cancer and how are they related to you?
- ☆ **What:** What type(s) of cancer did your relative have?
- ☆ **Age:** How old was your relative when they were diagnosed?

Instructions:

1. Please completely fill in the family history form to the best of your knowledge, including relatives who had cancer AND those who HAVE NOT.
2. Our assessment of your family history is most accurate if you can provide us with as much detailed information as possible. We encourage you to talk with your family members and to obtain medical records confirming cancer diagnosis whenever possible.

Have you ever had cancer: Yes No If **yes**, what type: _____

Age at diagnosis: _____ Date of diagnosis: _____

What type of treatment received: Chemotherapy: _____ Radiation: _____

Surgery: _____

Additional Comments Medical History: _____

Additional Comments Surgery History: _____



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Information About Your Children

M = Maternal P = Paternal

(If additional space is needed then please copy this page)

| Individual's Name <small>If half-sibling, please indicate by placing an asterisk * Your immediate family member's, only</small> | Gender | Age Today | Living Status | Affected by Cancer? <small>If yes, what type(s)</small> | Age Of Diagnosis |
|--|--|-----------|--|---|---------------------|
| Your child: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your child: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your child: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your child: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your child: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your child: _____ | <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |



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Information About Your Family Members

M = Maternal P = Paternal

(If additional space is needed then please copy this page)

| Individual's Name <small>If half-sibling, please indicate by placing an asterisk * Your family member's, only</small> | Gender | Age Today | Living Status | Affected by Cancer? <small>If yes, what type(s)</small> | Age Of Diagnosis |
|--|---------------------------------|-----------|--|---|------------------|
| Your Mother: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your Father: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your Brother(s): | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Brother: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Brother: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Brother: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Your Sister(s): | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Sister: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Sister: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Sister: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |



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Information About Your Mother's Family Members

M = Maternal P = Paternal

(If additional space is needed then please copy this page)

| Individual's Name If half-sibling, please indicate by placing an asterisk * Your Mother's Family | Gender | Age Today | Living Status | Affected by Cancer? If yes, what type(s) | Age Of Diagnosis |
|--|---------------------------------|-----------|--|---|------------------|
| Grandmother (M) Mother's mother: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Grandfather (M) Mother's father: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle(s): | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt(s): | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |



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Information About Your Father's Family Members

M = Maternal P = Paternal

(If additional space is needed then please copy this page)

| Individual's Name If half-sibling, please indicate by placing an asterisk * Your Father's Family | Gender | Age Today | Living Status | Affected by Cancer? If yes, what type(s) | Age Of Diagnosis |
|--|---------------------------------|-----------|--|---|------------------|
| Grandmother (P) Father's mother: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Grandfather (P) Father's father: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle(s): | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Uncle: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt(s): | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |
| Aunt: | <input type="checkbox"/> Female | | <input type="checkbox"/> Living <input type="checkbox"/> Deceased | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ | |



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Information About Your Other Family Member's (Nieces, Nephews, Cousins, etc.)

(M) = Maternal (P) = Paternal

(If additional space is needed then please copy this page)

| Individual's Name <small>If half-sibling, please indicate by placing an asterisk *</small> <small>Your other family member's, only</small> | Gender | Age Today | Living Status | Affected by Cancer? <small>If yes, what type(s)</small> | Age Of Diagnosis |
|--|---------------------------------|-----------|-----------------------------------|--|------------------|
| Name: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living | <input type="checkbox"/> No | |
| Relationship: | <input type="checkbox"/> Female | | <input type="checkbox"/> Deceased | <input type="checkbox"/> Yes _____ | |
| Name: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living | <input type="checkbox"/> No | |
| Relationship: | <input type="checkbox"/> Female | | <input type="checkbox"/> Deceased | <input type="checkbox"/> Yes _____ | |
| Name: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living | <input type="checkbox"/> No | |
| Relationship: | <input type="checkbox"/> Female | | <input type="checkbox"/> Deceased | <input type="checkbox"/> Yes _____ | |
| Name: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living | <input type="checkbox"/> No | |
| Relationship: | <input type="checkbox"/> Female | | <input type="checkbox"/> Deceased | <input type="checkbox"/> Yes _____ | |
| Name: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living | <input type="checkbox"/> No | |
| Relationship: | <input type="checkbox"/> Female | | <input type="checkbox"/> Deceased | <input type="checkbox"/> Yes _____ | |
| Name: | <input type="checkbox"/> Male | | <input type="checkbox"/> Living | <input type="checkbox"/> No | |
| Relationship: | <input type="checkbox"/> Female | | <input type="checkbox"/> Deceased | <input type="checkbox"/> Yes _____ | |