Genetic Risk Evaluation and Testing Program

Personal and Family History Questionnaire

INSTRUCTIONS: *Please complete this form to the best of your ability **PRIOR** to your appointment. Please remember to list **ALL** relatives, both living and deceased, regardless of if they have had cancer or not. If you are unsure about a family member's health history, please try to discuss this with a relative prior to the appointment. In addition, if any of your relatives have had genetic testing please bring a copy of their test results to your appointment.*

Name: ____ Date: ____

Date of Birth:_______________________________________ Email: ____

Address:____ City:____

State:____ Zip:____

Home Phone:____ Work Phone:_______________________________________

Cell Phone:____ Occupation: ____

Sex: Female / Male

Texas Oncology Physician:____________________________ Marital Status:_____________________________________

Referring Healthcare Provider:_________________________ Primary Care Physician:_____________________________

Race: ____

Your Mother's family ancestry (country/countries of origin prior to USA):_______________________________________

Your Father's family ancestry (country/countries of origin prior to USA):____

Do you have Central/Eastern European Jewish or Ashkenazi Jewish Ancestry in your family? (please circle selections)

Mother's family:	Yes	No	Unsure
Father's family:	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: ________________________

<u>PLEASE BRING THIS COMPLETED PACKET TO YOUR APPOINTMENT</u>

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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, chest wall 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?	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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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, ex adenoma) ____

6. Have you ever smoked? YES NO If Yes, How many packs per day________ How many years_________

   What age did you start smoking? __________________ What age did you stop smoking? ________________

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

8. **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 (OCPs)? YES NO Total # years taken ____________________

  What age did you start taking OCPs? __________________What age did you stop? ____________________

  Did you take them continuously during this time? YES NO
- Have you ever taken medication to increase fertility? YES NO
- 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? _________

9. Please list any allergies:____

____

10. Please list all your healthcare providers:

Healthcare Provider Name	Specialty

11. Please list surgeries and year surgery was completed and/or your age at the time:

Surgery	Year of surgery/Age

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

Condition	Year diagnosed/Age

13. Please list medications:

Medication	Dosage	Frequency

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YOUR FAMILY HEALTH HISTORY

PLEASE LIST ALL FAMILY MEMBERS EVEN THOSE WITHOUT CANCER

Add any additional family members 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.

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

Name	Sex	Current 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					

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

Name	Parent (ex: son John)	Sex	Current 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					
		M / F					

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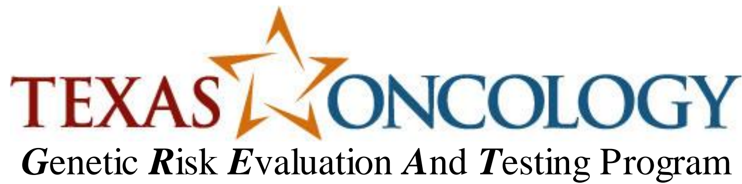
Your Brothers and Sisters: (Please list all, even those without cancer)

Name	Full or Half Sibling?	Sex	Current Age	Age at death	Type of Cancer	Age at diagnosis	Benign or Precancerous growth
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					
	□ Full Sibling □ Same Mother □ Same Father	M / F					

Your Nieces and Nephews: (Please list all, even those without cancer)

Name	Parent (Sister Mary)	Sex	Current 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					



Your Mother and Maternal Grandparents (Please list all, even those without cancer)

Relative	Name	Current Age	Age at Death	Type of Cancer	Age at Diagnosis	Benign or 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	Current 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					

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

Name	Parent (Uncle Joe)	Sex	Current 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					

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

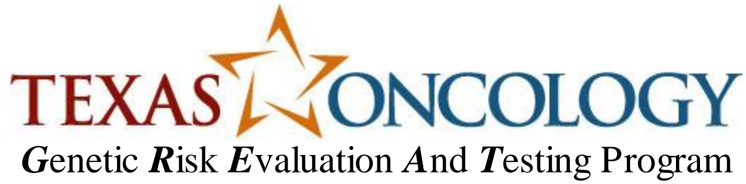
Relative	Name	Current Age	Age at Death	Type of Cancer	Age at Diagnosis	Benign or Precancerous Growth
Father						
Your Father's Mother						
Your Father's Father						

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

Name	Sex	Current 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					

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

Name	Parent (Uncle Joe)	Sex	Current 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					



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, family members 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)