



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:** _____

PLEASE BRING THIS COMPLETED PACKET TO YOUR APPOINTMENT

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Your Personal Health History

- Your weight: _____ (pounds) Your Height: _____
- 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: _____

- Please list any other genetic conditions, benign or precancerous growths you have had: _____

- 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? _____

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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					
	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
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F					
	<input type="checkbox"/> Full Sibling <input type="checkbox"/> Same Mother <input type="checkbox"/> 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					



TEXAS ONCOLOGY
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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					
	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					
		M / F					

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					
	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					
		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)