FAMILY HISTORY QUESTIONNAIRE

Name: _____

Appointment Date: _____

Please provide the following family history information in the tables below. Please include **all blood relatives** regardless of whether or not they have been diagnosed with cancer. If you require additional space for family members, attach one sheet of paper describing remaining relatives.

When complete, please return to the Genetic Counselor **before** your genetic counseling appointment. This information will allow appropriate preparation and review of family history to occur prior to your scheduled appointment.

Here is an example of how to complete this form:

	Current Age OR Age at Death	**Living** *Yes or No*	**Affected with cancer?** *Yes or No*	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**
You	50	Yes	Yes	Breast, Colon	45, 50

YOU, YOUR PARENTS, & SIBLINGS

	Current Age OR Age at Death	**Living** *Yes or No*	**Affected with cancer?** *Yes or No*	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**
You					
Your Mother					
Your Father					
Circle One: Sister or Brother					
Circle One: Sister or Brother					
Circle One: Sister or Brother					
Circle One: Sister or Brother					

YOUR CHILDREN

	Current Age OR Age at Death	**Living** ***Yes or No***	**Affected with cancer?** ***Yes or No***	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**
Circle One: Son or Daughter					
Circle One: Son or Daughter					
Circle One: Son or Daughter					
Circle One: Son or Daughter					

YOUR MATERNAL RELATIVES (Mom's Side)

	Current Age OR Age at Death	**Living** ***Yes or No***	**Affected with cancer?** ***Yes or No***	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**
Your mother's mother					
Your mother's father					
Circle One: Aunt or Uncle					
Circle One: Aunt or Uncle					
Circle One: Aunt or Uncle					
Circle One: Aunt or Uncle					

OTHER MATERNAL RELATIVES WITH CANCER (i.e. cousin-please indicate sex assigned at birth)

Relationship	**Sex**	**Current Age OR Age at Death**	**Living** ***Yes or No***	**Affected with cancer?** ***Yes or No***	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**

YOUR PATERNAL RELATIVES (Dad's Side)

	Current Age OR Age at Death	**Living** ***Yes or No***	**Affected with cancer?** ***Yes or No***	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**
Your father's mother					
Your father's father					
Circle One: Aunt or Uncle					
Circle One: Aunt or Uncle					
Circle One: Aunt or Uncle					
Circle One: Aunt or Uncle					

OTHER PATERNAL RELATIVES WITH CANCER (i.e. cousin-please indicate sex assigned at birth)

Relationship	**Sex**	**Current Age OR Age at Death**	**Living** ***Yes or No***	**Affected with cancer?** ***Yes or No***	**Location of Cancer (*ex. Breast, Lung, Prostate*)**	**Age at Cancer Diagnosis**

Please list the countries from which your family's ancestors came.

(i.e. German, Italian, African-American, Puerto Rican)

Your mother's side: _____

Your father's side: _____

Do you have any Ashkenazi Jewish ancestry? _____

If so, which side of the family? _____

Please list any additional history or concerns you would like to discuss:

_____

_____

Please return this form to eguilbert@holyredeemer.com or fax to 215-938-3547 to "Attn: Genetics" BEFORE your scheduled appointment. Thank you for taking the time to complete this form!

PERSONAL MEDICAL INFORMATION

Please complete the sections **which are applicable to you.**

Screening: (Indicate year, if never performed write "N/A")

Last colonoscopy: _____ Last PSA (prostate screening): _____

Number of polyps: _____ Last digital rectal exam (prostate screening): _____

Last skin screening: _____ Last mammogram: _____

Biopsies:

Have you had a previous biopsy? If so, how many and what site? (i.e. breast, skin, uterine)

_____

_____

Any atypical/precancerous cells on biopsy?

_____

_____

Surgeries: _____

Chronic Conditions/ Medical Issues: _____

Reproductive (Female Only):

Age at first menstrual period: _____
Number of pregnancies: _____
Number of live births: _____
How old were you when you had your first child? _____
Were your children breast fed? _____

Age at Menopause (if applicable): _____
Did you ever take: _____
Birth control pills? Y / N _____
Hormone Replacement? Y / N _____
Fertility meds? Y / N _____

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