

You, Your Parents & Your Grandparents

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
You			Y N		
Your Mother		Y N	Y N		
		Cause:			
Your Father		Y N	Y N		
		Cause:			
Your Mother's Mother		Y N	Y N		
		Cause:			
Your Mother's Father		Y N	Y N		
		Cause:			
Your Father's Mother		Y N	Y N		
		Cause:			
Your Father's Father		Y N	Y N		
		Cause:			

Your Children

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Daughter 1		Y N	Y N		
		Cause:			
Daughter 2		Y N	Y N		
		Cause:			
Daughter 3		Y N	Y N		
		Cause:			
Son 1		Y N	Y N		
		Cause:			
Son 2		Y N	Y N		
		Cause:			
Son 3		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Your Brothers and Sisters

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Sister 1		Y N	Y N		
		Cause:			
Sister 2		Y N	Y N		
		Cause:			
Sister 3		Y N	Y N		
		Cause:			
Brother 1		Y N	Y N		
		Cause:			
Brother 2		Y N	Y N		
		Cause:			
Brother 3		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Nieces and Nephews (Children of Your Brothers and Sisters)

FIRST NAME AND NAME OF PARENT	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Niece 1 (Parent)		Y N	Y N		
		Cause:			
Niece 2 (Parent)		Y N	Y N		
		Cause:			
Niece 3 (Parent)		Y N	Y N		
		Cause:			
Nephew 1 (Parent)		Y N	Y N		
		Cause:			
Nephew 2 (Parent)		Y N	Y N		
		Cause:			
Nephew 3 (Parent)		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Your Aunts and Uncles (Mother's side)

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Mother's Sister 1		Y N	Y N		
		Cause:			
Mother's Sister 2		Y N	Y N		
		Cause:			
Mother's Sister 3		Y N	Y N		
		Cause:			
Mother's Brother 1		Y N	Y N		
		Cause:			
Mother's Brother 2		Y N	Y N		
		Cause:			
Mother's Brother 3		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Cousins (Children of your Mother's Brothers and Sisters)

FIRST NAME AND NAME OF PARENT	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Cousin 1 (Parent)		Y N	Y N		
		Cause:			
Cousin 2 (Parent)		Y N	Y N		
		Cause:			
Cousin 3 (Parent)		Y N	Y N		
		Cause:			
Cousin 4 (Parent)		Y N	Y N		
		Cause:			
Cousin 5 (Parent)		Y N	Y N		
		Cause:			
Cousin 6 (Parent)		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Your Aunts and Uncles (Father's side)

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Father's Sister 1		Y N	Y N		
		Cause:			
Father's Sister 2		Y N	Y N		
		Cause:			
Father's Sister 3		Y N	Y N		
		Cause:			
Father's Brother 1		Y N	Y N		
		Cause:			
Father's Brother 2		Y N	Y N		
		Cause:			
Father's Brother 3		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Cousins (Children of your Father's Brothers and Sisters)

FIRST NAME AND NAME OF PARENT	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Cousin 1 (Parent)		Y N	Y N		
		Cause:			
Cousin 2 (Parent)		Y N	Y N		
		Cause:			
Cousin 3 (Parent)		Y N	Y N		
		Cause:			
Cousin 4 (Parent)		Y N	Y N		
		Cause:			
Cousin 5 (Parent)		Y N	Y N		
		Cause:			
Cousin 6 (Parent)		Y N	Y N		
		Cause:			
		Y N	Y N		
		Cause:			

Name: _____ Date of Birth: _____

Other Relatives with Cancer

(If it is a great aunt or great uncle, please be sure to indicate through which grandparent he or she is related)

FIRST NAME <u>AND</u> THEIR RELATION TO YOU	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
		Y N	Y N		
		Cause: _____			
		Y N	Y N		
		Cause: _____			
		Y N	Y N		
		Cause: _____			
		Y N	Y N		
		Cause: _____			
		Y N	Y N		
		Cause: _____			
		Y N	Y N		
		Cause: _____			

Background Information (some groups are at greater risk for hereditary cancer)

1. What is your race or ethnic background? Check all that apply.
 African American Asian Hispanic White Other _____

2. What is your family's country/countries of origin (other than the U.S.)?
 Examples: England, Spain, Germany, Russia...
 Mother's Family: _____
 Father's Family: _____

3. What is your family's religious background?
 Mother's Family: Ashkenazi Jewish Christian Muslim Sephardic Jewish Other _____
 Father's Family: Ashkenazi Jewish Christian Muslim Sephardic Jewish Other _____

4. What education have you completed?
 Elementary school High School College Degree Graduate Degree

5. What is your profession? _____

Health and Medical History

6. Are you an identical twin? No Yes

7. Have you ever had cancer? No Yes - Type: _____ Diagnosis Date: ____/____/____

8. Have you ever had a colonoscopy or flexible sigmoidoscopy (**circle which one**)? No Yes
 Date of most recent: ____/____/____
 Frequency: I have a colonoscopy/flexible sigmoidoscopy every _____ years.
 Age at first colonoscopy/flexible sigmoidoscopy: _____ years.
 How many colon polyps have you had (if any)? _____
 Type? (eg, hyperplastic, adenoma) _____ Please include any colon study records.

9. Have you ever had surgical removal of:
- | | | |
|------------------------|-----------------------------|--|
| Colon | <input type="checkbox"/> No | <input type="checkbox"/> Yes – When? ___/___/___ |
| Thyroid | <input type="checkbox"/> No | <input type="checkbox"/> Yes – When? ___/___/___ |
| Breast/s | <input type="checkbox"/> No | <input type="checkbox"/> Yes – When? ___/___/___ |
| Ovary/ies (women only) | <input type="checkbox"/> No | <input type="checkbox"/> Yes – When? ___/___/___ |
| Uterus (women only) | <input type="checkbox"/> No | <input type="checkbox"/> Yes – When? ___/___/___ |

Reproductive and Medical History (Men skip to the next section unless you have had a breast biopsy [13], mammogram/breast physical examination [20/21], or prostate cancer screening [23])

10. How old were you when you had your first menstrual period? _____
11. How old were you when your first child was born? (If you never had a child, enter “0”) _____
12. Number of mother, sister(s), daughter(s) with breast cancer? Total number _____
13. Have you ever had a breast biopsy? No Yes Don't Know
- a. If yes, how many breast biopsies have you had? _____
- b. Did the doctor ever tell you that your biopsy showed:
- | | | | |
|--|-----------------------------|------------------------------|-------------------------------------|
| atypical ductal hyperplasia (pre-cancerous)? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't Know |
| ductal carcinoma in situ (DCIS) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't Know |
| lobular carcinoma in situ (LCIS) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Don't Know |
14. How many pregnancies have you had? _____
15. How many miscarriages have you had? _____
16. How many stillbirths have you had? _____
17. How many pregnancy termination or abortions have you had? _____
- Were the terminations done because of birth defects in the fetus? No Yes
18. When was your last menstrual period? _____
19. Have you ever taken:
- | | | |
|---------------------------------------|-----------------------------|--|
| Birth Control Pills? | <input type="checkbox"/> No | <input type="checkbox"/> Yes - How long? ___ years |
| Estrogen/Hormone Replacement Therapy? | <input type="checkbox"/> No | <input type="checkbox"/> Yes - How long? ___ years |
| Fertility Drugs? | <input type="checkbox"/> No | <input type="checkbox"/> Yes - How long? ___ years |
20. Have you ever had a mammogram? No Yes
- Date of most recent: ___/___/___
- Frequency: I have mammography every _____ months
- Age at first mammogram: _____ years
21. Do you have regular physical examination of your breasts? No Yes
- By whom? Medical Doctor Nurse Self
22. Have you had a CA-125 blood test and/or transvaginal ultrasound (TVU) for ovarian cancer? No Yes
- CA-125: Date of most recent: ___/___/___ TVU: Date of most recent: ___/___/___
- Frequency: I have the CA-125 blood test every _____ months TVU every _____ months
- Age at first CA-125 blood test: _____ years Age at first TVU _____ years

Men Only

23. Have you ever had the prostate-specific antigen (PSA) blood test for prostate cancer? No Yes
- Date of most recent: ___/___/___
- Frequency: I have the PSA blood test every _____ months
- Age at first PSA blood test: _____ years

Lifestyle History

24. Have you ever smoked cigarettes regularly? No Yes
- If yes, do you currently smoke cigarettes? No Yes
- If yes, how many packs per day do you smoke? _____
25. Do you ever drink alcoholic beverages? No Yes
- If yes, how many drinks per week do you consume? _____

Additional Questions

Has anyone in your family undergone genetic testing for hereditary cancer? No Yes

If yes, please send us a copy of the original test result before your visit.

What issues do you want to address with the Cancer Genetic Counseling Service staff?

- cancer risks relative's cancer risk genetic testing
 cancer screening cancer prevention preventive surgery

Are there other issues you wish to discuss or questions you want answered during your visit with the Cancer Genetic Counseling Service?

Please provide the name and address or phone number of any physicians who you would like to receive a copy of your clinic consultation letter.

Name: _____

Address: _____

_____ (city) _____ (state) _____ (zip)

Phone: (____) _____

Name: _____

Address: _____

_____ (city) _____ (state) _____ (zip)

Phone: (____) _____

The Cancer Genetic Counseling Service publishes a newsletter entitled, *Pass It On* to update our patients and families on the latest developments in our program and in the field of cancer genetics. Just as genetic material is passed down in families; information regarding ways to fight a cancer family history should be shared and passed on as well, hence the name, *Pass It On*.

If you would like to receive our newsletter electronically, please indicate so by providing your email address below. The newsletter will also be available on our website at www.karmanos.org/genetics.

E-mail address: _____

Thank you for completing the family history questionnaire. Again, *please return it in the envelope provided as soon as possible before your appointment date*. You may also fax it to us at (313) 576-8699. Alternatively, you can complete it online at https://www.karmanos.org/Uploads/Public/Documents/Karmanos/Family_History2020.pdf and email it to genetics@karmanos.org.