

# FAMILY HISTORY QUESTIONNAIRE

Please complete this questionnaire to the best of your ability. While this can take some time, a review of your family history will allow us to provide you with hereditary cancer risk assessment, and to determine whether genetic testing would aid in the understanding of cancer for you and your family members. It is important that this form be returned before your appointment, as this information is needed for the genetic counselor to prepare for your visit.

The goal of genetic counseling is to help you learn more about the hereditary causes of cancer and how they affect you. During the appointment, the cancer in your family will be discussed and whether genetic testing may or may not be of benefit to you and your family members. If you receive genetic counseling, you are not obligated to pursue genetic testing. However, many insurance payers may require genetic counseling prior to genetic testing. On the day of your appointment, bring a photo ID and your insurance card with you. If your appointment is in less than one week, please bring this paperwork with you to your appointment.

#### PLEASE MAIL THE COMPLETED FORM TO:

Genetic Counseling Program

**Shaw Cancer Center** 

P.O. Box 2559, Edwards, CO 81632

or fax/e-mail to: 970-470-6675 / ShawPatientReferrals@VailHealth.org - ATTN: Genetics Counseling

**PLEASE NOTE:** If you or one of your close relatives has already had genetic counseling for cancer risk assessment and/or genetic testing, please send us the following: a copy of the pedigree and/or detailed family history, consultation summary, and genetic test results on you or your relative(s).

#### INSTRUCTIONS FOR COMPLETING THE FAMILY MEDICAL HISTORY CHARTS:

- Please fill in all the questions asked and columns as completely as possible.
- Please record ALL relatives, even if they do/did not have cancer or the medical condition of concern.
- Please give as much information as possible about current ages, ages at death and ages of cancer diagnosis. Approximate ages are better than no ages at all. Do not leave off ages.
- If you have no relatives in any of the categories listed, please put an 'X' in the space for 'NONE'.
- Write **UNK** (unknown) if you do not know, or **NA** (not applicable) if the information requested does not apply.
- If individuals have had colon polyps, please write the number of polyps they had and the age at which they were found.
- If females have had their uterus or ovaries removed, please write what age the surgery took place.

PERSONAL INFOR	MATION							
Legal Name:			Date o	f Birth:		Male	Female	
Address:								
Telephone: Home:		Work:			Cell:			
Email(s):			Referri	ng Doctor:				
What specific questi	·	·	netic cou	nselor?				
Ancestry/race/ethnic			ply):					
White/Caucasian		Latina/Latir	no/Hispani	С	African	American/E	Black	
Asian/Asian Americ	an	Native Ame	erican/Alas	kan Native	Multirac	Multiracial		
Other (specify):								
If known, please list	the specific cou	ntries wher	e vour di	stant ance	estors originat	ed·		
Father's Side:	and specime cou		Mother's		originat			
Because some healt answer these questions Is your father or are his	ons:		equently i	n certain . No	Jewish popula	ations, ple	ase	
Is your mother or are h	er ancestors Ashk	enazi Jewish	? Yes	No	Unsure			
FOR ALL PATIENTS Working? Yes N		Occupation (n	ow and/o	previous):				
Exposures to work or e	nvironmental che	micals? Y	'es No	Describe	:			
Tobacco Use (current c	r previous):	Y	'es No	Describe:	:			
Alcohol Use (current or	previous):	Υ	'es No	Describe:	:			
Non-prescription drug	s (recreational):	Y	'es No	Describe:	:			

Weight:

Height:

# Do you have any of the following (please check box)?

Arthritis	Asthma	Bleeding problems	Blood clots
Blood disorder	s Colitis	Diabetes	Emphysema/COPD
Gastroesophag	eal Reflux	Glaucoma	Heart attack
Heart failure	High cholesterol	High blood pressure	Kidney stones
Liver problems	Pneumonia	Seizures	Stroke
Thyroid proble	ms Other:		

# If you checked any of the above, please provide details and age at onset:

Have you ever been diag	nosed with can	cer? Yes	No				
If yes, please provide: Dia	ignosis:						
Age(s) at time of diagnos	is: T	reatment:					
Additional information:							
List past surgeries and da	tes:						
List current medications v	vith dose and f	requency:					
Age at first colonoscopy?		How	often do	you h	ave colo	noscop	pies?
Number of colonoscopie	s you have had	?					
Were any polyps found?	Yes No	Unsure	If yes,	how	many po	lyps we	ere found?
Polyps found at what age	?						
Por women only Date of last mammogram Age at your first menstrua Number of children and a	: al period:	Age at first o			Nur		t Pap smear: pregnancies:
Ovaries removed: Yes	No If yes, at	what age?	Uter	us rem	noved:	Yes	No If yes, at what age?
Are you: Premenopau	sal Perimen	opausal	Postmer	opau	sal	Ag	e at menopause:
Oral birth control pills or	normone repla	cement ther	apy use:	Ν	lever		Current user
Total # of years used:		More than	5 years	ago		Less th	an 5 years ago
	es vou have had	d?					
Number of breast biopsis	.5 you have had						
Number of breast biopsies  Have any breast biopsies			sia"?	Yes	No	Unsur	e If yes, at what age?

Date of last PSA testing:

Date of last prostate/rectal exam:

PSA test result:

### **IMMEDIATE FAMILY:**

Family Member/ Relationship	Full Name	Living?	Current age or age at death	Gender	Types of cancer(s)/ Tumor(s)/Polyps	Age cancer(s)/ polyps found	Other hereditary or medical conditions
You		Yes No		Male Female			
Your Spouse/ Partner		Yes		Male			
Children		No Yes		Female Male			
(if your children have		No Yes		Female Male			
different parents,		No		Female			
please write the parent's name in		Yes No		Male Female			
brackets)  None		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
Your Father		Yes No		Male Female			
Your Mother		Yes No		Male Female			
Brothers & Sisters		Yes No		Male Female			
(if you have half siblings, please		Yes No		Male Female			
indicate the shared parent in		Yes No		Male Female			
brackets) None		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			

# **IMMEDIATE FAMILY (CONTINUED):**

Family Member/ Relationship	Full Name	Living?	Current age or age at death	Gender	Types of cancer(s)/ Tumor(s)/Polyps	Age cancer(s)/ polyps found	Other hereditary or medical conditions
Neices & Nephews		Yes No		Male Female			
(please write the name of your brother		Yes No		Male Female			
or sister, who is the parent, in brackets)		Yes No		Male Female			
None		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
Grand- children (please write		Yes No		Male Female			
the name of your child, who is the		Yes No		Male Female			
parent, in brackets)		Yes No		Male Female			
None		Yes No		Male Female			
_		Yes No		Male Female			
_		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			

### **FATHER'S SIDE OF FAMILY:**

Family Member/ Relationship	Full Name	Living?	Current age or age at death	Gender	Types of cancer(s)/ Tumor(s)/Polyps	Age cancer(s)/ polyps found	Other hereditary or medical conditions
Your Grandfather		Yes		Male			
		No		Female			
Your Grandmother		Yes No		Male Female			
Aunts & Uncles		Yes No		Male Female			
(if your aunts and uncles have		Yes		Male Female			
different parents,		Yes		Male			
please write the parent that is shared		No Yes		Female Male			
in brackets) None		No Yes		Female Male			
		No Yes		Female Male			
		No		Female			
Cousins (please write		Yes No		Male Female			
the name of your aunt or uncle, who is		Yes No		Male Female			
the parent, in brackets)  None		Yes No		Male Female			
None		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			

### **MOTHER'S SIDE OF FAMILY:**

Family Member/ Relationship	Full Name	Living?	Current age or age at death	Gender	Types of cancer(s)/ Tumor(s)/Polyps	Age cancer(s)/ polyps found	Other hereditary or medical conditions
Your Grandfather		Yes		Male			
		No		Female			
Your Grandmother		Yes No		Male Female			
Aunts & Uncles		Yes No		Male Female			
(if your aunts and uncles have		Yes		Male Female			
different parents,		Yes		Male			
please write the parent that is shared		No Yes		Female Male			
in brackets) None		No Yes		Female Male			
		No Yes		Female Male			
		No		Female			
Cousins (please write		Yes No		Male Female			
the name of your aunt or uncle, who is		Yes No		Male Female			
the parent, in brackets)  None		Yes No		Male Female			
None		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			
		Yes No		Male Female			

#### **ADDITIONAL FAMILY MEMBERS:**

Please use this space to provide information on additional family members that you did not have space for on the previous pages. Make as many copies of this page as you need. **NOTE: Please** make sure to provide how each person is related to you and if they are on your mother's or father's side of the family.

Family Member/ Relationship	Full Name	Living?	Current age or age at death	Gender	Types of cancer(s)/ Tumor(s)/Polyps	Age cancer(s)/ polyps found	Other hereditary or medical conditions
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male Female			
		No					
		Yes No		Male Female			
		Yes		Male			
		No Yes		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			
		Yes		Male			
		No		Female			