SHAW CANCER CENTER
VAIL HEALTH
A service of Vail Health Hospital

You may keep this page.

Appointment: _____ at _____ AM PM

322 Beard Creek Road
Edwards, CO 81632

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 INFORMATION:

Legal Name: _____ Date of birth: ____/____/____ ☐ Male ☐ Female

Address: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email(s): _____ Referring Doctor:_____

What specific questions do you have for the genetic counselor?

_____

_____

To help with risk assessment:

Ancestry/race/ethnicity (please mark all that apply):

☐ White/Caucasian ☐ Latina/Latino/Hispanic ☐ African American/Black
☐ Asian/Asian American ☐ Native American/Alaskan Native ☐ Multiracial
☐ Other (*specify*): _____

If known, please list the *specific countries where your distant ancestors originated*:

Father's side: _____ Mother's side: _____

Because some health conditions occur more frequently in certain Jewish populations, please answer these questions:

Is your father or are his ancestors Ashkenazi Jewish? ☐ Yes ☐ No ☐ Unsure
Is your mother or are her ancestors Ashkenazi Jewish? ☐ Yes ☐ No ☐ Unsure

For all patients:

Working? ☐ Yes ☐ No ☐ Retired Occupation (now and/or previous): _____
Exposures to work or environmental chemicals? ☐ Yes ☐ No Describe: _____
Tobacco Use (current or previous): ☐ Yes ☐ No Describe: _____
Alcohol Use (current or previous): ☐ Yes ☐ No Describe: _____
Non-prescription drugs (recreational): ☐ Yes ☐ No Describe: _____
Height: _____ Weight: _____
Do you have any of the following (please check box)?

Arthritis		Asthma		Bleeding problems		Blood clots		Blood disorders	
Colitis		Diabetes		Emphysema/COPD		Gastroesophageal Reflux		Glaucoma	
Heart attack		Heart failure		High cholesterol		High blood pressure		Kidney stones	
Liver problems		Pneumonia		Seizures		Stroke		Thyroid problems	
Other:									

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

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, please provide: Diagnosis: _____
Age(s) at time of diagnosis: _____ Treatment: _____
Additional information: _____

List past surgeries and dates: _____
_____

List current medications with dose and frequency: _____
_____

Age at first colonoscopy? _____ How often do you have colonoscopies? _____ Number of colonoscopies you have had? _____
Were any polyps found? ☐ Yes ☐ No ☐ Unsure If yes, how many polyps were found? _____ Polyps found at what age? _____

For women only:

Date of last mammogram: _____ Date of last Pap smear: _____ Age at your first menstrual period: _____
Age at first childbirth: _____ Number of pregnancies: _____ Number of children and ages: _____
Ovaries removed: ☐ No ☐ Yes If yes, at what age? _____ Uterus removed: ☐ No ☐ Yes If yes, at what age? _____
Are you: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal Age at menopause: _____
Oral birth control pills or hormone replacement therapy use: ☐ Never ☐ Current user Total # of years used: _____
☐ More than 5 years ago ☐ Less than 5 years ago
Number of breast biopsies you have had? _____
Have any breast biopsies revealed "atypical hyperplasia"? ☐ Yes ☐ No ☐ Unsure If yes, at what age? _____
Have any biopsies revealed "lobular neoplasia"? ☐ Yes ☐ No ☐ Unsure If yes, at what age? _____

For men only:

Date of last prostate/rectal exam: _____ Date of last PSA testing: _____ PSA test result: _____

IMMEDIATE FAMILY:

Family Member	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		☐ Female ☐ Male			
Spouse/ Partner		☐ Yes ☐ No		☐ Female ☐ Male			
Children (if your children have different parents, please write the parent's name in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Your Father		☐ Yes ☐ No		☐ Female ☐ Male			
Your Mother		☐ Yes ☐ No		☐ Female ☐ Male			
Brothers and Sisters (if you have half siblings, please indicate the shared parent in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

IMMEDIATE FAMILY (continued):

Family Member	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
Nieces and Nephews (please write the name of your brother or sister, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Grand-children (please write the name of your child, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

FATHER'S SIDE OF FAMILY:

Family Member	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 Grand-father		☐ Yes ☐ No		☐ Female ☐ Male			
Your Grand-mother		☐ Yes ☐ No		☐ Female ☐ Male			
Aunts and Uncles (if your aunts and uncles have different parents, please write the parent that is shared in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Cousins (please write the name of your aunt or uncle, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

MOTHER'S SIDE OF FAMILY:

Family Member	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 Grand-father		☐ Yes ☐ No		☐ Female ☐ Male			
Your Grand-mother		☐ Yes ☐ No		☐ Female ☐ Male			
Aunts and Uncles (if your aunts and uncles have different parents, please write the parent that is shared in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
Cousins (please write the name of your aunt or uncle, who is the parent, in brackets) ☐ None		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			
		☐ Yes ☐ No		☐ Female ☐ Male			

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	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
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			
Relationship?		☐ Yes ☐ No		☐ Female ☐ Male			