Renown HEALTH

Patient Name:

Date of Birth:

Date Completed:

Personal & Family History of Cancer Questionnaire

Please read this information carefully before completing the following family history questionnaire.

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE:

- Please fill in the family history questionnaire as completely as you can. Our assessment of your family history is most accurate if you can provide us with as much detailed information as possible. We encourage you to talk with your family members and to obtain records confirming cancer diagnosis whenever possible.
- Please list ALL relatives on form including relatives who have had cancer AND those who have not.
- Information should be provided on biological relatives only (do not provide information about adopted, foster, or step-relatives).
    - Indicate half-siblings with an asterisk (*) by their initials.
        I. Indicate material half-siblings (same mother, different father) with *M.
        II. Indicate paternal half-siblings (same father, different mother) with *P.
- If exact age is not known, please approximate (e.g. early 40's, late 60's).
- If requested information is not known, please write "unknown".
- If additional space is needed, please attach another sheet of paper and indicate which question is being addressed.

QUESTIONS WE WILL BE ASKING:

- Relationship to you (e.g. mother, father, sister, etc.)
- Specific type of cancer (e.g. breast, colon, ovarian, etc.)
- Unilateral or bilateral (e.g. one breast or both breasts)
- Second cancer – for relatives who developed a second cancer, die the second cancer result from spreading of the first cancer or was it considered a separate new cancer?)
- Environmental exposures (e.g. smoking, radiation, asbestos, etc.)
- Current age/age and cause of death.
- Colon polyps, how many and what type.
- History of hysterectomy and/or ovary removal.
- History of genetic testing.

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PERSONAL MEDICAL HISTORY (MALES & FEMALES):

1. Do you currently have or have you ever had cancer? ☐ Yes ☐ No
    - If yes, what type?
    - Age and Year of diagnosis:
    - What type of treatment(s) did you have or are planning?
    - At what hospital were you diagnosed and treated?

SOCIAL HISTORY (MALES & FEMALES):

1. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
2. Occupation:
3. Education:
4. Tobacco? ☐ Yes ☐ No
    - Type and how often:
5. Alcohol? ☐Yes ☐No
    - Type and how often:
6. Exercise? ☐Yes ☐No
    - Type and how often:

MEDICAL HISTORY (MALES ONLY):

1. Colonoscopy? Yes☐No☐
    - If yes, indicate the year and age for each:
    - If yes, were polyps detected? ☐ Yes ☐ No
2. Prostate Cancer Screening? ☐ Yes ☐ No
    - If yes, how often and at what age did you start:

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MEDICAL HISTORY (FEMALES ONLY):

1. Age began menstrual period:
2. Age at first childbirth:
3. Did you ever breastfeed? ☐Yes ☐No
   - If yes, how long?
4. Ever had a breast biopsy? ☐Yes ☐No
   - If yes, where the results abnormal? ☐Yes ☐No
   - If abnormal, when was it performed and what were the specific results?
5. Have you ever used oral contraceptives? ☐Yes ☐No
   - If yes, how many years in total (does not have to be consecutive)?
6. Have you ever had:
   - Hysterectomy (uterus removed)? ☐Yes ☐No
   - Oophorectomy (ovaries & fallopian tube removed)? ☐Yes ☐No
   - If yes for either, at what age?
7. Have you entered menopause? ☐Yes ☐No
   - If yes, at what age?
8. Have you ever had hormone replacement therapy? ☐Yes ☐No
   - If yes, how long and what type?
9. Breast self-exams ☐Yes ☐No
   - If yes, how often?
10. Clinical breast exam by a doctor? ☐Yes ☐No
    - If yes, how often?
11. Mammograms? ☐Yes ☐No
    - If yes, how often?
12. Breast MRI's? ☐Yes ☐No
    - If yes, how often?
13. Ovarian screening (CA-125 and/or transvaginal u/s)? ☐Yes ☐No
    - If yes, how often?
14. Colonoscopy? ☐Yes ☐No
    - If yes, indicate year and age for each:
    - If yes, were polyps detected? ☐Yes ☐No
      - If yes, how many and what type?

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YOUR IMMEDIATE FAMILY: CHILDREN							
Name of Individual	Male/Female	If living, current age	If deceased, age at death	Cause of death	Affected with cancer? If yes, what type of cancer was the primary site/diagnosis	Age at cancer diagnosis	Does this person have children?
1.	☐Male ☐Female						# Sons: # Daughters:
2.	☐Male ☐Female						# Sons: # Daughters:
3.	☐Male ☐Female						# Sons: # Daughters:
4.	☐Male ☐Female						# Sons: # Daughters:
5.	☐Male ☐Female						# Sons: # Daughters:
6.	☐Male ☐Female						# Sons: # Daughters:

HAVE ANY OF THE ABOVE RELATIVES EVER HAD:

1. Hysterectomy (removal of uterus) and/or oophorectomy (removal of ovaries and fallopian tubes)? ☐ Yes ☐No ☐Unknown
   - If yes, please list details, if known (age at surgery, ovaries removed?): _____

   _____

2. Colonoscopy? ☐Yes ☐No ☐Unknown
   - If yes, please list details if known (age and if/how many polyps detected?): _____

   _____

3. Genetic testing: ☐Yes ☐No ☐Unknown
   - If yes, please list details and if possible obtain/send copy of the report: _____

   _____

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YOUR IMMEDIATE FAMILY: SIBLINGS & PARENTS – please mark individuals with a * if a half-sibling and indicate either material (M) or paternal (P).							
Name of Individual	Male/Female	If living, current age	If deceased, age at death	Cause of death	Affected with cancer? If yes, what type of cancer was the primary site/diagnosis	Age at cancer diagnosis	Does this person have children?
Your Mother	Female						
Your Father	Male						
Siblings 1.	☐Male ☐Female						# Sons: # Daughters:
2.	☐Male ☐Female						# Sons: # Daughters:
3.	☐Male ☐Female						# Sons: # Daughters:
4.	☐Male ☐Female						# Sons: # Daughters:

Complete the table below ONLY if any of your nieces and nephews have had cancer.					
*	Name of Niece or Nephew	Name of Parent	Current Age or Age at Death	Type of Cancer	Age at Diagnosis

HAVE ANY OF THE ABOVE RELATIVES EVER HAD:

1. Hysterectomy (removal of uterus) and/or oophorectomy (removal of ovaries and fallopian tubes)? ☐Yes ☐No ☐Unknown
   - If yes, please list details, if known (age at surgery, ovaries remove?): _____

   _____

2. Colonoscopy: ☐Yes ☐No ☐Unknown
   - If yes, please list details if known (age and if/how many polyps detected?): _____

   _____

3. Genetic testing: ☐Yes ☐No ☐Unknown
   - If yes, please list details and if possible obtain/send copy of the report: _____

   _____

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YOUR MOTHERS FAMILY: GRANDPARENTS, AUNTS & UNCLES – please mark individuals with a * if a half-sibling and indicate either material (M) or paternal (P).							
Name of Individual	Male/Female	If living, current age	If deceased, age at death	Cause of death	Affected with cancer? If yes, what type of cancer was the primary site/diagnosis	Age at cancer diagnosis	Does this person have children?
Your Maternal Grandmother	Female						
Your Maternal Grandfather	Male						
Maternal Aunt/Uncles 1.	☐Male ☐Female						# Sons: # Daughters:
2.	☐Male ☐Female						# Sons: # Daughters:
3.	☐Male ☐Female						# Sons: # Daughters:
4.	☐Male ☐Female						# Sons: # Daughters:

Complete the table below ONLY if any of your first cousins have had cancer.					
*	Name of Cousin0	Name of Parent	Current Age or Age at Death	Type of Cancer	Age at Diagnosis

HAVE ANY OF THE ABOVE RELATIVES EVER HAD:

1. Hysterectomy (removal of uterus) and/or oophorectomy (removal of ovaries and fallopian tubes)? ☐Yes ☐No ☐Unknown
   - If yes, please list details, if known (age at surgery, ovaries remove?): _____

   _____

2. Colonoscopy: ☐Yes ☐No ☐Unknown
   - If yes, please list details if known (age and if/how many polyps detected?): _____

   _____

3. Genetic testing: ☐Yes ☐No ☐Unknown
   - If yes, please list details and if possible obtain/send copy of the report: _____

   _____

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YOUR FATHER'S FAMILY: GRANDPARENTS, AUNTS & UNCLES – please mark individuals with a * if a half-sibling and indicate either material (M) or paternal (P).							
Name of Individual	Male/Female	If living, current age	If deceased, age at death	Cause of death	Affected with cancer? If yes, what type of cancer was the primary site/diagnosis	Age at cancer diagnosis	Does this person have children?
Your Paternal Grandmother	Female						
Your Paternal Grandfather	Male						
Paternal Aunt/Uncles 1.	☐Male ☐Female						# Sons: # Daughters:
2.	☐Male ☐Female						# Sons: # Daughters:
3.	☐Male ☐Female						# Sons: # Daughters:
4.	☐Male ☐Female						# Sons: # Daughters:

Complete the table below ONLY if any of your first cousins have had cancer.					
*	Name of Cousin	Name of Parent	Current Age or Age at Death	Type of Cancer	Age at Diagnosis

HAVE ANY OF THE ABOVE RELATIVES EVER HAD:

1. Hysterectomy (removal of uterus) and/or oophorectomy (removal of ovaries and fallopian tubes)? ☐Yes ☐No ☐Unknown
   - If yes, please list details, if known (age at surgery, ovaries remove?): _____

   _____

2. Colonoscopy: ☐Yes ☐No ☐Unknown
   - If yes, please list details if known (age and if/how many polyps detected?): _____

   _____

3. Genetic testing: ☐Yes ☐No ☐Unknown
   - If yes, please list details and if possible obtain/send copy of the report: _____

   _____

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OTHER FAMILY MEMBERS WHO HAVE HAD CANCER: GREAT GRANDPARENTS, GREAT AUNTS & UNCLES, 2nd COUSINS, ETC.							
Name of Individual	Male/Female	If living, current age	If deceased, age at death	Cause of death	Affected with cancer? If yes, what type of cancer was the primary site/diagnosis	Age at cancer diagnosis	Does this person have children?
1.	☐Male ☐Female						# Sons: # Daughters:
2.	☐Male ☐Female						# Sons: # Daughters:
3.	☐Male ☐Female						# Sons: # Daughters:
4.	☐Male ☐Female						# Sons: # Daughters:
5.	☐Male ☐Female						# Sons: # Daughters:
6.	☐Male ☐Female						# Sons: # Daughters:

HAVE ANY OF THE ABOVE RELATIVES EVER HAD:

1. Hysterectomy (removal of uterus) and/or oophorectomy (removal of ovaries and fallopian tubes)? ☐Yes ☐No ☐Unknown
   - If yes, please list details, if known (age at surgery, ovaries remove?): _____

   _____
2. Colonoscopy: ☐Yes ☐No ☐Unknown
   - If yes, please list details if known (age and if/how many polyps detected?): _____

   _____
3. Genetic testing: ☐Yes ☐No ☐Unknown
   - If yes, please list details and if possible obtain/send copy of the report: _____

   _____