Oregon Health & Science University – Knight Cancer Institute
Cancer Genetics Family History Questionnaire

Updated 10/2/19

Instructions:

1) Please list all your blood relatives, (including living and deceased; both full- and half-siblings), and whether or not they have had cancer. Please attach more pages if necessary.
2) You may need to speak with other relatives to increase the accuracy of the information on this questionnaire. We understand that sometimes information is just not available to you. However, the more information you are able to provide, the more accurate our assessment.
3) If you have any questions about completing the questionnaire, please contact the medical genetics scheduling at 503-494-8307 Please return the questionnaire by email: MMGPASR@ohsu.edu or FAX: 503-346-8268 Attn: Genetic Counselor

Your Name____ **Date of Birth**_____/_____/_______

(first) **(middle)** **(last)** **(maiden)** **Date of Consult**____/____/______

Your Siblings (sisters and brothers) – please note if any siblings are half-siblings and which parent you share

	Sex (M/F)	Living?	Affected with Cancer? Yes or No	Type of cancer and age at diagnosis	# of Children	Have any of their children been diagnosed with cancer? (Y/N) If yes, please note which type of cancer and age at diagnosis
Example	*F*	□*Yes, current age: ____78____* □*No, age at death: ____ ______* *Cause of death:* __________________________	*Yes*	*Yes* *breast at 46 and ovarian at 77*	*# Males:_1_* *#Females:_2_*	*Yes* *daughter with breast cancer at age 45*
Sibling 1		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: __________________________			# Males: ____ # Females:___	
Sibling 2		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: __________________________			# Males: ____ # Females:___	
Sibling 3		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: __________________________			# Males: ____ # Females:___	
Sibling 4		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: __________________________			# Males: ____ # Females:___	

Your mother, her siblings, and your maternal grandparents

	Sex (M/F)	Living?	Affected with Cancer? Yes or No	Type of cancer and age at diagnosis	# of Children	Have any of their children been diagnosed with cancer? (Y/N) If yes, please note which type of cancer and age at diagnosis
Your Mother		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Mother's Sibling 1		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Mother's Sibling 2		□Yes, current age: __________ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Mother's Sibling 3		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Mother's Sibling 4		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Your mother's mother		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Your mother's father		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	

Your father, his siblings, and your paternal grandparents

	Sex (M/F)	Living?	Affected with Cancer? Yes or No	Type of cancer and age at diagnosis	# of Children	Have any of their children been diagnosed with cancer? (Y/N) If yes, please note which type of cancer and age at diagnosis
Your Father		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	
Father's Sibling 1		□Yes, current age: ____ ______ □No, age at death: __________ Cause of death: ___________________________			# Males: ____ # Females:___	

Father's Sibling 2		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Father's Sibling 3		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Father's Sibling 4		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Your father's mother		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Your father's father		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	

Your Children

	Sex (M/F)	Living?	Affected with Cancer? Yes or No	Type of cancer and age at diagnosis	# of Children	Have any of their children been diagnosed with cancer? (Y/N) If yes, please note which type of cancer and age at diagnosis
Child1		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Child 2		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Child 3		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	
Child 4		□Yes, current age: __________ □No, age at death: __________ Cause of death: ____________________________			# Males: ____ # Females:___	

To what country do you trace your ancestors (for example: England, Germany, Mexico, Vietnam, Nigeria)?

Your Mom's Family____
Ashkenazi Jewish descent □ yes □ no

Your Dad's Family____
Ashkenazi Jewish descent □ yes □ no

Have you been diagnosed with cancer? ☐ **yes** ☐ **no** **If yes, which type(s) and age at diagnosis?**_____________________________________
Treatment(s) included? (check all that apply) ☐ surgery ☐ chemotherapy ☐ radiation ☐ other____

<u>Additional Screening and Health History Questions</u>
Do you currently smoke? ☐ yes ☐ no Chew tobacco? ☐ yes ☐ no Have you previously smoked or chewed tobacco? ☐ yes ☐ no

<u>For Women</u>

Breast

Date of last mammogram_____/_____/_________ Date of last breast MRI _____/_____/_________
Have you ever had a breast biopsy? ☐ yes ☐ no
If yes, how many?__________ Year(s)?___________ Result? ☐ benign ☐ atypia ☐ other_________________________

Ovary

Date of last transvaginal ultrasound_____/_____/_________

Colon

Date of last colonoscopy_____/_____/_________ Polyps? ☐ yes ☐ no If yes, how many?___________

Gynecologic/Obstetric History

Age at menarche (first period)_________ Age at first live birth_________ Age at menopause_________
Have you had a hysterectomy (removal of the uterus)? ☐ yes ☐ no Have you had an oophorectomy (removal of the ovaries)? ☐ yes ☐ no

<u>For Men</u>

Colon

Date of last colonoscopy_____/_____/_________ Polyps? ☐ yes ☐ no If yes, how many?__________

Prostate

Date of last digital rectal exam (DRE) _____/_____/_________ Result? ☐ normal ☐ abnormal
Date of last prostate-specific antigen (PSA) _____/_____/_________ Result? ☐ normal ☐ elevated If elevated, level?_________
Have you ever had a biopsy of your prostate? ☐ yes ☐ no
If yes, how many?__________ Year(s)?___________ Result? ☐ benign ☐ atypia ☐ other_________________________

Has anyone in your family had genetic testing? ☐ **yes** ☐ **no**
Results____
Please attach a copy of the genetic test result if possible

Please feel free to write in any additional comments or information you feel is important for us to know:

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*****Please bring a list of current medications and allergies to your appointment*****
Thank you for taking the time to complete this questionnaire. The information will help us prepare for your visit.