Genetic Risk Assessment Questionnaire

In order to assess the risk for hereditary cancer in your family, we need to review your medical and family history, focusing on the history of cancer. The first part of the questionnaire focuses on your personal and medical history, the second part on your family history. If you are uncertain about any information, please write in your best approximation or write unknown. You may decline to answer any or all of the questions at this time or at any later time. This information is well protected with us, and we do not share any patient data with third parties.

Personal History

Please use tick mark and circle Y (yes), N (no) or U (unknown).

BACKGROUND INFORMATION

Name_____(_____)

_____ First Name Maiden/Family Name

Last Name

Date of birth_____/____/_____ **Occupation** _____

Marital Status Single/Divorced _ Widowed _ Married/Partner ____ Name of Spouse/Partner_____Age _____

_____ _____

Address

_____

MEDICAL HISTORY

How is your health in general (Diabetes/ Blood Pressure) _____

_____

Have you ever been diagnosed with cancer? Y N U If yes, what type(s) and at what age(s) were you diagnosed?

Age	Cancer Type	Treatment (Circle all that apply)
_____	_____	Surgery Chemotherapy Radiation Therapy
_____	_____	Surgery Chemotherapy Radiation Therapy
_____	_____	Surgery Chemotherapy Radiation Therapy

MEN ONLY

Have you had a prostatectomy (removal of the prostate)? Y N U

If yes, at what age?_____ Reason _____

Have you had a transurethral resection of the prostate (TURP)? Y N U

If yes, at what age?_____ Reason _____

MEN AND WOMEN

Have you had a colectomy (removal of colon)? Y N U

If yes, at what age? ____If yes,_____Partial Complete ___Unknown Reason _____

Have you had a mastectomy (removal of breasts)? Y N U

If yes, at what age(s)__ If yes,_ Right__Left___Prophylactic Reason_____

WOMEN ONLY

Age at first period _____ Age at first birth _____ Number of children _____ Number of miscarriages _____ Number of stillbirths _____

Have you ever used oral contraceptives? Y N U If yes, how many years and at what age(s)? _____

Have you gone through menopause yet? Y N U If yes, at what age _____

Have you taken hormone replacement therapy? Y N U If yes, how many years?

_____ Have you had any breast biopsies? Y N U If yes, how many? _____

If yes, at what age(s)?_____ Did the biopsy show atypical hyperplasia? Y N U DCIS or LCIS? Y N U _____

Have you had a hysterectomy (removal of uterus)? Y N U

If yes, at what age?_____ Reason _____

Have you had a oophorectomy (Removal of ovaries)? Y N U

If yes, at what age?_____ If yes,_____Right_____Left_____Prophylactic Reason _____

Please indicate any other surgeries: _____

_____

Any major birth defects, genetic disorders or inherited conditions Y N U . If yes, describe _____

_____

Do you smoke or use tobacco products: Currently? Y N **Previously?** Y N **If yes, what do you use and how much?** _____

Do you drink alcohol beverages? Y N **If yes, how often?**_____1-3/week_____4-6/week_____>6/week_____Other:_____

Any other routine screenings: _____

-
_____

Family History

Parents

Name (Optional)	Year of Birth or Approx. Age	Deceased	Year or Approx Age of Death	Cancer	Cancer Type or General Health	Age at Diagnosis
		Y / N / U		Y / N / U		
		Y / N / U		Y / N / U		

Siblings & cousins

Name (Optional)	Sex	Year of Birth or Approx. Age	Relation	Deceased	Year or Approx Age of Death	Cancer	Cancer Type or General Health	Age at Diagnosis
	M / F			Y / N / U		Y / N / U		
	M / F			Y / N / U		Y / N / U		
	M / F			Y / N / U		Y / N / U		
	M / F			Y / N / U		Y / N / U		
	M / F			Y / N / U		Y / N / U		
	M / F			Y / N / U		Y / N / U		

Grandparents

Name (Optional)	Approx. Age	Maternal / Paternal	Deceased	Year or Approx Age of Death	Cancer	Cancer Type or General Health	Age at Diagnosis
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		

Uncles/Aunts

Name (Optional)	Approx. Age	Maternal / Paternal	Deceased	Year or Approx Age of Death	Cancer	Cancer Type or General Health	Age at Diagnosis
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		
			Y / N / U		Y / N / U		

Notes/Any other history/details: _____

_____

Please attach clinical reports if any along with this form.

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