



### **Genetic Risk Assessment Questionnaire**

In order to determine the risk for hereditary cancer in your family, we need to review your medical and family history, focusing on the history of cancer.

- If you are uncertain about any information, please write in your best approximation or write unknown.
- You may decline to answer any of these questions.
- Please take some time before your appointment to gather as much of your family history information as possible.
- We will not use the information you provide to contact your family members.
- Bring the questionnaire to your genetics appointment. You do not need to send it in advance.
- If you have any questions, please contact Bobbi McGivern, MS, CGC or Megan Nelson, MS, CGC at 920-380-1500 or by email at [bobbi.mcgivern@thedacare.org](mailto:bobbi.mcgivern@thedacare.org) or [megan.nelson@thedacare.org](mailto:megan.nelson@thedacare.org)

## GENETIC RISK ASSESSEMENT – Personal History

Put an X in the space next to the category that is most accurate or fill out as indicated. Please circle Y (yes), N (no) or U (unknown).

### BACKGROUND INFORMATION

Name \_\_\_\_\_ ( \_\_\_\_\_ ) \_\_\_\_\_ Date Completed \_\_\_\_\_

First Name

Maiden/Family Name

Last Name

What is your date of birth? \_\_\_\_/\_\_\_\_/\_\_\_\_ What is your occupation? \_\_\_\_\_

**Marital Status** Single \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Married/Partner \_\_\_\_ Name of Partner \_\_\_\_\_ Age \_\_\_\_

**Please choose the ethnic/racial background that best describes you and your biological mother and father.** (Check all that apply)

Mother      Father

Countries of Origin (example: England, Germany, Mexico)

\_\_\_\_ \_\_\_\_ White/Caucasian

Maternal side: \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Black or African-American

Paternal side: \_\_\_\_\_

\_\_\_\_ \_\_\_\_ Asian

**Are either of your parents of Ashkenazi**

\_\_\_\_ \_\_\_\_ Spanish, Hispanic or Latino

**(Eastern/Central European) Jewish descent?**      Y    N    U

\_\_\_\_ \_\_\_\_ Other \_\_\_\_\_

### GENERAL MEDICAL HISTORY

How is your health in general? \_\_\_\_\_

Please list any chronic medical conditions \_\_\_\_\_

**Have you ever been diagnosed with any 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      Other

\_\_\_\_      \_\_\_\_\_      Surgery    Chemotherapy    Radiation Therapy      Other

\_\_\_\_      \_\_\_\_\_      Surgery    Chemotherapy    Radiation Therapy      Other

Notes \_\_\_\_\_

**WOMEN ONLY**

Age at first period \_\_\_\_\_ Age at first birth \_\_\_\_\_ Number of children \_\_\_\_\_ Have you had more than 3 pregnancy losses? Y N

Did you take any drugs to try to get pregnant (IVF, clomid, etc)? Y N U

Have you ever used birth control pills? Y N U If yes, how many years and at what age(s)? \_\_\_\_\_

Have you gone through menopause yet? Y N U Have you taken hormone replacement therapy? Y N U If yes, how many years? \_\_\_\_\_

Did you ever breastfeed? Y N U If yes, how long TOTAL? \_\_\_\_\_

Have you had any breast biopsies? Y N U If yes, how many? \_\_\_\_\_ At what age(s)? \_\_\_\_\_ What was found? \_\_\_\_\_

Have you had a hysterectomy (removal of uterus)? Y N U If yes, at what age? \_\_\_\_\_ What was the reason? \_\_\_\_\_

Have you had a oophorectomy (removal of ovaries)? Y N U Were both ovaries removed? Y N U

**MEN ONLY**

Have you had a prostatectomy (removal of the prostate)? Y N U If yes, at what age? \_\_\_\_\_

Have you had a transurethral resection of the prostate (TURP)? Y N U If yes, at what age? \_\_\_\_\_

**MEN AND WOMEN**

Have you had a colectomy (removal of colon)? Y N U If yes, at what age? \_\_\_\_\_ Partial \_\_\_\_\_ Complete \_\_\_\_\_

Have you had a mastectomy (removal of breasts)? Y N U If yes, at what age? \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_

Have you had a thyroidectomy (removal of thyroid)? Y N U If yes, at what age? \_\_\_\_\_

Please indicate any other major surgeries: \_\_\_\_\_

**Has a doctor ever told you that you had any of the following conditions?**

- Any major birth defects, genetic disorders or inherited conditions Y N U (This includes conditions such as cleft palate/lip, heart defects, club feet, spina bifida, etc.) If yes, describe \_\_\_\_\_

**Do you smoke or use tobacco products:** Currently? Y N Previously? Y N If current, how much? \_\_\_\_\_

**How much alcohol do you drink?** \_\_\_\_\_ none \_\_\_\_\_ occasionally \_\_\_\_\_  $\leq 7$  per week \_\_\_\_\_ 8 - 14 per week \_\_\_\_\_  $>15$  per week

**Have you ever had depression, anxiety, bipolar disorder or other mental condition?** Y N U \_\_\_\_\_

**How would you rate your concern about developing cancer (or additional cancer)?** (1=no concern; 5=extremely) 1 2 3 4 5

## SCREENING HISTORY

### WOMEN

#### SCREENING TESTS

Most Recent

How Often

Result

#### Breast Screening

Mammogram

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Breast MRI

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Gynecologic Screening

PAP Smear/Pelvic Exam

\_\_\_\_\_

\_\_\_\_\_

If Yes, any abnormal? Y N U

CA 125 blood test (for ovarian cancer )

Yes

No

Unknown

Ultrasound of ovaries/uterus

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### MEN

Digital Rectal Exam

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PSA Blood Test (for prostate cancer)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### MEN AND WOMEN

Exam of the colon/rectum with a scope (colonoscopy or sigmoidoscopy)

\_\_\_\_\_

\_\_\_\_\_

If Yes, any polyps found? Y N U

Upper Endoscopy (scope down your throat to view stomach and throat)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Skin Examination

\_\_\_\_\_

\_\_\_\_\_

If Yes, any skin biopsies Y N U

Height \_\_\_\_\_ ft \_\_\_\_\_ in

Weight \_\_\_\_\_ lbs

**For Office use only:** HC (cm) \_\_\_\_\_ (male 58.0cm; female 57.3cm)

## GENETIC RISK ASSESSEMENT - Family History

### Your Biological Children

Name	Sex	Year of Birth or Approximate Age	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	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		
	M / F		Y / N / U		Y / N / U		
	M / F		Y / N / U		Y / N / U		

### Your Biological Parents

Name	Year of Birth or Approx. Age	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	Age at Diagnosis
		Y / N / U		Y / N / U		
		Y / N / U		Y / N / U		

Please list any adopted children here: \_\_\_\_\_

Notes: \_\_\_\_\_

### Your Biological Brother and Sisters, include full and half (with and without cancer)

Name	Sex	Year of Birth or Approx. Age	Full or Half Sibling	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	Age at Diagnosis
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		

\*same mother and father as you

### Your Nieces and Nephews - children of your brothers and sisters (with cancer)

Name	Sex	Year of Birth or Approx. Age	Child of	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	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		

### Your Mother's Parents

Name	Year of Birth or Approx. Age	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	Age at Diagnosis
		Y / N / U		Y / N / U		
		Y / N / U		Y / N / U		

### Your Mother's Brother and Sisters - include full and half (with and without cancer)

Name	Sex	Year of Birth or Approx. Age	Full or Half	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	Age at Diagnosis
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		

\*Same mother and father as your mother

### Your Father's Parents

Name	Year of Birth or Approx. Age	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	Age at Diagnosis
		Y / N / U		Y / N / U		
		Y / N / U		Y / N / U		

### Your Father's Brother and Sisters - include full and half (with and without cancer)

Name	Sex	Year of Birth or Approx. Age	Full or Half	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	Age at Diagnosis
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		
	M / F		Same Father* Y / N Same Mother* Y / N	Y / N / U		Y / N / U		

\*same mother and father as your father



### Your Paternal Cousins - children of your paternal aunts/uncles (with cancer)

Name	Sex	Year of Birth or Approx. Age	Child of	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	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		

### Your Maternal Cousins - children of your maternal aunts/uncles (with cancer)

Name	Sex	Year of Birth or Approx. Age	Child of	Deceased	Year or Approx Age of Death	Cancer	If yes, Cancer Type	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		

Other Relatives (with cancer)							
Name	Sex	Year of Birth or Approx. Age	Relationship to you	Deceased	Year or Approx Age of Death	Cancer Type	Age at Diagnosis
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			
	M / F			Y / N / U			

Other Comments:

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