PRIVATE AND CONFIDENTIAL

CANCER GENETICS SERVICE
FAMILY HISTORY QUESTIONNAIRE

ST. JAMES'S HOSPITAL

You have been referred to the Cancer Genetics Service because of a history of cancer in you and/or your family. Please complete this questionnaire which will help us to assess whether or not your family history places you at an increased risk of cancer and if increased surveillance and/or genetic testing would be recommended.

Please return this questionnaire within 4 weeks to us at

Cancer Genetics Department, St James's Hospital, Dublin 8.

Please attempt to complete as many sections as possible. The more details you can provide, the more accurate we can be in our assessment. It is important to include those family members (alive and deceased) who have had, as well as those who have not had cancer, as this will have a bearing on your overall cancer risk.

If any members of your family have attended genetics services here or elsewhere it may not be necessary for you to complete all of this form. We may already have the information we need, or may be able to obtain it from another genetics service with permission. Please give your relative's details on the back page. Please also let us know details of any family members already on our waiting list.

If you have any queries or difficulties in completing the questionnaire, please do not hesitate to contact us on 01 410 3759. Even if you are unable to complete all the sections, please return the form. If another copy is required please log on to our website to download another copy

www.stjames.ie/Departments/DepartmentsA-Z/C/CancerGenetics/GPInformation/

Name:	GP Name: .....
Date of Birth: ..... / ..... /	GP Address: .....
Address:	.....
.....	.....
Eircode:	Telephone: .....
Telephone:	

For office use only:
MRN: Date FHQ received: Family Ref No PED:

Please complete the form below, giving as much information as possible about your immediate (blood) relatives, including those who have NOT had cancer.
If there is any information you do not know, perhaps someone in your family will be able to help you, otherwise leave that box empty.
Enclose any death certificates you have for deceased relatives with cancer. (Continue onto additional paper if required)

	For all relatives					For relatives who have had cancer/polyps				
Relative	**First Name and Surname** (including maiden and any previous names)	**Sex**	**Date of Birth** or approx. year	**Is the person alive** Yes / No	**Date of death** or approx. year	**Which part of body was affected by cancer**	**Age when cancer found**	**Hospital(s) where treated** Please give name of specialist if known	**Can we write to this person to ask to view their medical records?** Yes/No	**If Yes, provide relative's address**
Self										
Your children (or write none)	1.									
	2.									
	3.									
	4.									
Your sisters (please indicate if half-sister)	1.									
	2.									
	3.									
	4.									
Your brothers (please indicate if half-brother)	1.									
	2.									
	3.									
	4.									

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		For all relatives				For relatives who have had cancer/polyps				
Relative	**First Name and Surname** (including maiden and any previous names)	**Sex**	**Date of Birth** or approx. year	**Is the person alive** Yes / No	**Date of death** or approx. year	**Which part of body was affected by cancer**	**Age when cancer found**	**Hospital(s) where treated** Please give name of specialist if known	**Can we write to this person to ask to view their medical records?** Yes/No	**If Yes, provide relative's address**
Your mother										
Your father										
Your mother's mother										
Your mother's father										
Your mother's brothers and sisters	1.									
	2.									
	3.									
	4.									
Your father's mother										
Your father's father										
Your father's brothers and sisters	1.									
	2.									
	3.									
	4.									

If any other relatives have had cancer (cousins etc.), please include details on a separate sheet of paper stating clearly how they are related to you e.g. maternal aunt's daughter

Have you or any other members of your family attended a genetics service before? If yes:

- Name: .....
- Date of birth: ..... / ..... / .....
- Where seen: .....
- When (date): ..... / ..... / .....
- Relationship to you: .....
- Family reference number, if known: .....

Have you or any other members of your family ever had a genetic test? If yes:
Please give test details e.g. where, result if known

.....

Some types of genetic cancers are slightly more common in certain ethnic groups or those of Jewish ancestry:

- Do you or any of your relatives have Jewish ancestry? ☐ Yes ☐ No

  If yes, which family member: .....

- Are you or any of your relatives of Eastern European origin? ☐ Yes ☐ No

  If yes, which family member: .....

Please complete this section if you are receiving any cancer surveillance (screening)

Type of screening e.g. mammogram /colonoscopy	How often?	Date of most recent screening	Hospital name and consultant if known

What are your main questions which you would like to discuss with the Cancer Genetics Team?

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Thank you for completing this questionnaire. Please return it to the above address.

Once we have reviewed this Family History Questionnaire one of the following may occur:

- We may write to you with screening advice, but not offer an appointment
- We may advise that your relative with cancer is seen by a genetics service
- We may offer you a telephone appointment
- We may offer you a face to face appointment at one of our clinics