

Personal and Family History Questionnaire

It is very important for you to complete this form to the best of your ability and **return it well in advance of your scheduled appointment**. This allows us appropriate time to prepare, so the consultation is as beneficial as possible. You may also receive a brief phone call to clarify or gather additional info. Please consult with other family members, if necessary, to increase the accuracy of this information.

INFORMATION ABOUT YOU

Name: _____ **Date of Birth:** _____
First Middle Last (Prior Names)

Insurance Type (e.g. BC/BS, Cigna, Medicare, Medical): _____ **Plan Type:** ☐ HMO ☐ PPO ☐ EPO

Marital Status: _____ **Occupation:** _____ **Referring Provider:** _____

Paternal Ancestors Country of Origin (e.g., Ireland, Korea, Lebanon, Chile, etc.): _____

Maternal Ancestors Country of Origin (e.g., Estonia, Japan, Togo, Venezuela, etc.): _____

Is your family of Central/Eastern European (Ashkenazi) Jewish ancestry? ☐ Yes ☐ No

Females Only:

Age at menarche (first period): _____ Amount of time on birth control pills: ☐ N/A _____

How many times have you been pregnant: _____ Age at birth of first child: ☐ N/A _____

Amount of time breast feeding: ☐ N/A _____ Amount of time on hormone replacement therapy: ☐ N/A _____

Age at menopause: _____ Do you do monthly self-breast exams? ☐ Y ☐ N ☐ Sometimes

Age at first mammogram: _____ Do you get annual mammograms? ☐ Y ☐ N ☐ Sometimes

How many breast biopsies have you had? _____

How many were normal? Number: _____ ☐ Don't know

How many were "atypical ductal hyperplasia (ADH)"? Number: _____ ☐ Don't know

How many were "lobular carcinoma in situ (LCIS)" or "lobular neoplasia"? Number: _____ ☐ Don't know

Have you had a mastectomy (surgical removal of one or both breasts)? ☐ No ☐ One (left or right?) ☐ Both

Have you had a hysterectomy (surgical removal of uterus)? ☐ Yes ☐ No

Have you had an oophorectomy (surgical removal of one or both ovaries)? ☐ No ☐ One (left or right?) ☐ Both

Have you ever taken Tamoxifen (to treat or prevent breast cancer)? ☐ Yes ☐ No Amount of time Tamoxifen taken?: _____

Female & Males:

Smoking history?: ☐ Never ☐ Previous Smoker: # years? _____ Average amount smoked per day? _____ Quit in what year? _____

☐ Current Smoker: # years? _____ How much do you smoke per day? _____

Average number of alcoholic drinks per week?: _____

How many colonoscopies have you had?: _____ In what year(s)? _____

Cumulative number of polyps identified on colonoscopy?: _____

Pathology of polyps if known (e.g. adenomas, hyperplastic, hamartomatous)? _____

Have you ever had an upper endoscopy (EGD)? ☐ Yes ☐ No If yes, what were the findings? _____

In your routine life, how many days per week do you exercise? _____ If yes, what form of exercise? _____

Have you ever had a medical condition treated with radiation? ☐ Yes ☐ No If yes, explain? _____

Your Cancer History:

Type(s) of Cancer: _____ Age(s) at Diagnosis: _____

Other History (i.e. uterine fibroids, other benign tumors, thyroid disease, etc.): _____

GENETIC TESTING HISTORY FOR YOU

Have you ever pursued cancer genetic testing in the past? ☐ Yes ☐ No

If Yes, in what year? _____

If Yes, which genes were tested? _____

If Yes, which lab performed the testing? (examples: Myriad, Ambry, Invitae, GeneDx, Counsyl, Color, LabCorp, Quest)

IF YES, PLEASE INCLUDE A COPY OF YOUR GENETIC TEST RESULT WITH THIS COMPLETED QUESTIONNAIRE.

GENETIC TESTING HISTORY FOR YOUR FAMILY MEMBERS

Have any of your family members ever pursued cancer genetic testing in the past? ☐ Yes ☐ No

If Yes, which family member(s), and please denote whether the relative is maternal or paternal?

If Yes, in what year(s)? _____

If Yes, which genes were tested? _____

If Yes, which lab performed the testing? (examples: Myriad, Ambry, Invitae, GeneDx, Counsyl, Color, LabCorp, Quest)

IF YES, PLEASE INCLUDE A COPY OF YOUR FAMILY MEMBER'S GENETIC TEST RESULT WITH THIS COMPLETED QUESTIONNAIRE.

FAMILY HISTORY

YOUR PARENTS				
	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Mother	<input type="checkbox"/> deceased			
Father	<input type="checkbox"/> deceased			

YOUR CHILDREN (WITH OR WITHOUT CANCER)					
	Gender	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Child 1	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 2	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 3	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 4	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 5	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 6	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 7	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Child 8	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			

YOUR BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)					
<u>If half-sibling, please denote maternal-half or paternal-half</u>	Gender	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Sibling 1	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 2	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 3	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 4	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 5	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 6	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 7	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Sibling 8	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			

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YOUR NIECES AND NEPHEWS (WITH OR WITHOUT CANCER)

	Gender	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Niece / Nephew 1 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 2 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 3 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 4 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 5 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 6 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 7 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 8 Child to sibling # _____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			

YOUR GRANDPARENTS

	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Maternal Grandmother	<input type="checkbox"/> deceased			
Maternal Grandfather	<input type="checkbox"/> deceased			
Paternal Grandmother	<input type="checkbox"/> deceased			
Paternal Grandfather	<input type="checkbox"/> deceased			

YOUR MOTHER'S BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)

<u>Please denote if maternal or paternal half-sibling to your mother</u>	Gender	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Aunt / Uncle 1	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 2	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 3	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 4	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 5	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 6	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 7	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 8	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			

YOUR FATHER'S BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)

Please denote if maternal or paternal half-sibling to your father	Gender	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Aunt / Uncle 1	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 2	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 3	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 4	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 5	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 6	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 7	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Aunt / Uncle 8	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			

ANY OTHER EXTENDED BLOOD RELATIVES (ONLY LIST IF THEY HAVE A HISTORY OF CANCER)

List anyone else with cancer such as your 1st & 2nd cousins and grandparents' siblings

Denote Relationship (i.e. first cousin, etc.) and circle M for maternal or P for paternal; For first cousins please also denote which # aunt or uncle is their parent	Gender	Current Age -OR- Age at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
M / P	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			

Please return the completed questionnaire to us PRIOR to your scheduled appointment. Thank you! If you

have any questions please do not hesitate to call us (650) 497-1290

Email to DL-CSCS@stanfordhealthcare.org

-OR- Fax: (650) 498-5150