BARBARA ANN Karmanos CANCER INSTITUTE Wayne State University

Cancer Genetic Counseling Service

Family History Questionnaire

Today's Date: ____/____/____ **Appointment Date:** ____/____/____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. Sex assigned at birth: ☐ Male ☐ Female Gender: _____

Name: _____
(last) (maiden) (first) (middle)

Address: _____

_____
(city) (state) (zip)

Phone: Home: (____)_____ Work: (____)_____

Mobile: (____)_____ E-mail address: _____

Which number is the preferred number to call for scheduling your appointment? ☐ Home ☐ Work ☐ Mobile

Date of Birth: ____/____/____ **Your Age:** _____ **Height:** _____ **Weight:** _____

Will anyone be attending your appointment with you? ☐ No ☐ Yes, Who? _____

Once you have completed the questionnaire, ***please return it in the envelope provided as soon as possible before your appointment date***. You may also fax it to us at (313) 576-8699. Alternatively, you can complete it online at: karmanos.org/geneticsfamilyquestionnaire and email it to genetics@karmanos.org. We may be calling you to ask more questions about your family history; therefore, you may want to keep a copy of this questionnaire for future reference.

Family History

Your family history is the most important tool we have in determining whether the cancer in your family may be hereditary. Please complete the questions as best you can. You may need to contact other family members to increase the accuracy of this information. **Your personalized cancer risk assessment depends not only on those relatives with cancer, but also those who do not have cancer. Therefore, we are interested in learning about all relatives.** Just a reminder: include information on blood relatives only. If there is not enough space for all relatives to be listed, please list answers on a separate page. **Also, if you do not know the exact age at cancer diagnosis, please estimate as best you can (e.g., 50s or 60s-70s).**

EXAMPLE: Your mother was diagnosed with breast cancer at age 45 and ovarian cancer at age 50. She died at the age of 62. You would fill in the chart as shown below. If your father is living and has not had cancer, you would complete the chart as shown in the second line.

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Your Mother Mary	62	[Y] N	[Y] N	Breast Ovarian	Age 45 Age 50
Your Father Bill	60	Y [N]	Y [N]		

You, Your Parents & Your Grandparents

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
You			Y N		
Your Mother		Y N Cause:	Y N		
Your Father		Y N Cause:	Y N		
Your Mother's Mother		Y N Cause:	Y N		
Your Mother's Father		Y N Cause:	Y N		
Your Father's Mother		Y N Cause:	Y N		
Your Father's Father		Y N Cause:	Y N		

Your Children

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Daughter 1		Y N Cause:	Y N		
Daughter 2		Y N Cause:	Y N		
Daughter 3		Y N Cause:	Y N		
Son 1		Y N Cause:	Y N		
Son 2		Y N Cause:	Y N		
Son 3		Y N Cause:	Y N		
		Y N Cause:	Y N		

Your Brothers and Sisters

(If half sibling, please indicate from which parent)

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Sister 1		Y N Cause:	Y N		
Sister 2		Y N Cause:	Y N		
Sister 3		Y N Cause:	Y N		
Brother 1		Y N Cause:	Y N		
Brother 2		Y N Cause:	Y N		
Brother 3		Y N Cause:	Y N		
		Y N Cause:	Y N		

Nieces and Nephews (Children of Your Brothers and Sisters)

FIRST NAME AND NAME OF PARENT	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Niece1 (Parent)		Y N Cause:	Y N		
Niece 2 (Parent)		Y N Cause:	Y N		
Niece 3 (Parent)		Y N Cause:	Y N		
Nephew 1 (Parent)		Y N Cause:	Y N		
Nephew 2 (Parent)		Y N Cause:	Y N		
Nephew 3 (Parent)		Y N Cause:	Y N		
		Y N Cause:	Y N		

Your Aunts and Uncles (Mother's side)

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Mother's Sister 1		Y N Cause:	Y N		
Mother's Sister 2		Y N Cause:	Y N		
Mother's Sister 3		Y N Cause:	Y N		
Mother's Brother 1		Y N Cause:	Y N		
Mother's Brother 2		Y N Cause:	Y N		
Mother's Brother 3		Y N Cause:	Y N		
		Y N Cause:	Y N		

Cousins (Children of your Mother's Brothers and Sisters)

Only include cousins affected with cancer

FIRST NAME AND NAME OF PARENT	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Cousin 1 (Parent)		Y N Cause:	Y N		
Cousin 2 (Parent)		Y N Cause:	Y N		
Cousin 3 (Parent)		Y N Cause:	Y N		
Cousin 4 (Parent)		Y N Cause:	Y N		
Cousin 5 (Parent)		Y N Cause:	Y N		
Cousin 6 (Parent)		Y N Cause:	Y N		
		Y N Cause:	Y N		

Your Aunts and Uncles (Father's side)

FIRST NAME	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Father's Sister 1		Y N Cause:	Y N		
Father's Sister 2		Y N Cause:	Y N		
Father's Sister 3		Y N Cause:	Y N		
Father's Brother 1		Y N Cause:	Y N		
Father's Brother 2		Y N Cause:	Y N		
Father's Brother 3		Y N Cause:	Y N		
		Y N Cause:	Y N		

Cousins (Children of your Father's Brothers and Sisters)

Only include cousins affected with cancer

FIRST NAME AND NAME OF PARENT	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
Cousin 1 (Parent)		Y N Cause:	Y N		
Cousin 2 (Parent)		Y N Cause:	Y N		
Cousin 3 (Parent)		Y N Cause:	Y N		
Cousin 4 (Parent)		Y N Cause:	Y N		
Cousin 5 (Parent)		Y N Cause:	Y N		
Cousin 6 (Parent)		Y N Cause:	Y N		
		Y N Cause:	Y N		

Other Relatives with Cancer

(If it is a great aunt or great uncle, please be sure to indicate through which grandparent they are related)

FIRST NAME AND THEIR RELATION TO YOU	AGE OR AGE AT DEATH	IS THIS RELATIVE DECEASED?	AFFECTED WITH CANCER?	LOCATION OF CANCER (BREAST, LUNG, ETC.)	AGE AT CANCER DIAGNOSIS
		Y N Cause:	Y N		
		Y N Cause:	Y N		
		Y N Cause:	Y N		
		Y N Cause:	Y N		
		Y N Cause:	Y N		

Background Information ***(some groups are at greater risk for hereditary cancer)***

1. What is your race or ethnic background? Check all that apply.
   ☐ African American ☐ Asian ☐ Hispanic ☐ White ☐ Other _____
2. Were you adopted? ☐ No ☐ Yes
3. Is there any consanguinity in your family (i.e., are your parents or grandparents blood related?) ☐ No ☐ Yes
   If yes, specify who and type of relation (cousins, siblings, etc.) _____
4. What is your family's country/countries of origin (other than the U.S.)?
   Examples: England, Spain, Germany, Russia…

   Mother's Family: _____

   Father's Family: _____
5. What is your family's religious background?

   Mother's Family: ☐ Ashkenazi Jewish ☐ Christian ☐ Muslim ☐ Sephardic Jewish ☐ Other_____

   Father's Family: ☐ Ashkenazi Jewish ☐ Christian ☐ Muslim ☐ Sephardic Jewish ☐ Other_____
6. What education have you completed?
   ☐ Elementary school ☐ High School ☐ College Degree ☐ Graduate Degree
7. What is your profession? _____

Health, Reproductive, and Medical History ***(If not applicable to you, leave blank)***

8. Are you an identical twin? ☐ No ☐ Yes
9. Have you ever had cancer? ☐ No ☐ Yes - Type: _____ Diagnosis Date: ____/____/____
10. Have you ever had a colonoscopy or flexible sigmoidoscopy (**circle which one**)? ☐ No ☐ Yes
    Date of most recent: ___/___/___
    Frequency: I have a colonoscopy/flexible sigmoidoscopy every _____ years.
    Age at first colonoscopy/flexible sigmoidoscopy: _____ years.
    How many total colon polyps have you had (if any)? _____ Age at first colon polyps: _____ years
    Type? (eg, hyperplastic, adenoma) _____ Please include any colon study records.

11. Have you ever used Cologuard for colon cancer screening? □ No □ Yes
    a. Date of most recent: ____/____/____
    b. Age at first Cologuard: ____
    c. Frequency of Cologuard: □ Every year □ Every 3 years □ Every 5 years □ Every 10 years □ Other: _____

12. Have you ever had an upper endoscopy? □ No □ Yes
    a. Reason? _____
    b. What year did you have your most recent upper endoscopy? _____

13. Have you ever had radiation therapy? □ No □ Yes

14. Have you ever had chemotherapy? □ No □ Yes

15. Have you ever had a bone marrow transplant? □ No □ Yes

16. Have you ever had surgical removal of:

Colon	□ No	□ Yes – When? ___/___/___
Thyroid	□ No	□ Yes – When? ___/___/___
Breast/s	□ No	□ Yes – When? ___/___/___
Ovary/ies	□ No	□ Yes – When? ___/___/___
Uterus	□ No	□ Yes – When? ___/___/___

17. Have you ever had a mammogram? □ No □ Yes
    Date of most recent: ___/___/___
    Frequency: I have mammography every _____ months
    Age at first mammogram: _____ years

18. Do you have regular physical examination of your breasts? □ No □ Yes
    By whom? (select all that apply) □ Medical Doctor □ Nurse □ Self

19. Have you ever had a breast MRI? □ No □ Yes
    a. How old were you when you had your first breast MRI? _____
    b. Date of most recent: ____/____/____
    c. Frequency of breast MRI's: □ Every year □ Every other year □ Other: _____

20. Have you ever had a breast biopsy? □ No □ Yes □ Don't Know
    a. If yes, how many breast biopsies have you had? _____
    b. Did the doctor ever tell you that your biopsy showed:

atypical ductal hyperplasia (pre-cancerous)?	□ No	□ Yes	□ Don't Know
ductal carcinoma in situ (DCIS)	□ No	□ Yes	□ Don't Know
lobular carcinoma in situ (LCIS)	□ No	□ Yes	□ Don't Know

21. Has a doctor ever told you that you have benign breast disease? □ No □ Yes

22. Have you had a CA-125 blood test and/or transvaginal ultrasound (TVU) for ovarian cancer? □ No □ Yes
    CA-125: Date of most recent: ___/___/___ TVU: Date of most recent: ___/___/___
    Frequency: I have the CA-125 blood test every _____ months TVU every _____months
    Age at first CA-125 blood test: _____ years Age at first TVU _____ years

23. Have you ever had the prostate-specific antigen (PSA) blood test for prostate cancer? □ No □ Yes
    Date of most recent: ___/___/___
    Frequency: I have the PSA blood test every _____ months
    Age at first PSA blood test: _____ years

24. Have you ever taken:

Birth control pills, shots, or patches?	□ No	□ Yes - How long? ____ years
Estrogen/Hormone Replacement Therapy?	□ No	□ Yes - How long? ____ years
Fertility Drugs?	□ No	□ Yes - How long? ____ years

25. How old were you when you had your first menstrual period, (if you have had one)? _____

26. Which of the following best describes you?
- □ I am still having periods
- □ I am having periods off and on
- □ I stopped having periods
  a. Your age when periods stopped? _____
  b. Reason they stopped? □ Natural aging (menopause) □ Uterus and/or ovary/ies removed □ Uterine ablation □ Chemotherapy □ Other
- □ Other/I am not sure

27. Are you currently pregnant? □ No □ Yes, Due date? ___/___/___

28. How old were you when your first child was born? _____

29. How many pregnancies have you had? _____

30. Your total number of live births? _____

31. Your total number of miscarriages, abortions, or stillbirths? _____

Lifestyle History

32. Have you ever used tobacco or nicotine products? □ No □ Yes

33. Have you ever smoked cigarettes? □ No □ Yes
a. If yes, on average of the entire time you smoked, how many cigarettes per day do/did you smoke? _____
b. How many years have/had you smoked? _____
c. Do you currently smoke cigarettes? □ No □ Yes

34. How often do you drink alcohol? □ Never □ Occasionally □ Less than 2 drinks per week
□ One drink every other day □ One drink a day □ Two drinks most days □ More than 2 drinks most days

Cancer Worries

35. How worried are you about getting (or having a recurrence) of cancer someday?
□ Not at all □ Rarely □ Sometimes □ Often □ Almost all the time

36. How much does your worry affect your mood?
□ Not at all □ Rarely □ Sometimes □ Often □ Almost all the time

37. How much does your worry affect your ability to perform your daily activities?
□ Not at all □ Rarely □ Sometimes □ Often □ Almost all the time

Additional Questions

38. Has anyone in your family undergone genetic testing for hereditary cancer? □ No □ Yes
If yes, please send us a copy of the original test result before your visit.

39. What issues do you want to address with the Cancer Genetic Counseling Service staff?
□ cancer risks □ relative's cancer risk □ genetic testing
□ cancer screening □ cancer prevention □ preventive surgery

40. What is the reason for your visit with the Cancer Genetic Counseling Service?

_____

41. Are there other issues you wish to discuss or questions you want answered during your visit with the Cancer Genetic Counseling Service?

_____

_____

Please provide the name and address or phone number of any physicians who you would like to receive a copy of your clinic consultation letter.

(1) Name: _____

Address: _____

_____
(city) (state) (zip)

Phone: (_____)_____

(2) Name: _____

Address: _____

_____
(city) (state) (zip)

Phone: (_____)_____

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If you have any questions, please call our office at (313) 576-8748. For more information about our services and frequently asked questions, please visit our website at: karmanos.org/geneticcounseling