



**The C. R. Wood Cancer Center
Hereditary Cancer & Genetics Program**

102 Park Street
Glens Falls, NY 12801
(518) 926-6620
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**Hereditary Cancer and Genetics Program
Personal and Family History Questionnaire**

Dear _____,

We have received a referral requesting an appointment for genetic counseling and cancer risk assessment.

Prior to your appointment, we ask that you take the time to fill out the enclosed questionnaire and to investigate your own medical history and your family history of cancer to the best of your ability. This information will help us to understand who you are and to provide you with the best information. Some questions only pertain to women and some only to men. Please skip questions that are not applicable.

Please complete the enclosed questionnaire and return to us at:

C.R. Wood Cancer Center - Genetics Program
102 Park Street
Glens Falls, NY 12801
Attn: Genetic Counselors

**If you have not already received an appointment time, please complete and return this questionnaire.
We will contact you to schedule your appointment once the packet is returned.**

Please feel free to contact Lois, our patient scheduling specialist at 518-926-6526 with any questions that you may have about our process. Our genetic counselors will review this form with you during your visit and will answer any questions or concerns that you may have.

There is a team of cancer care professionals available to you at the C.R. Wood Cancer Center and we are interested in helping both you and those who are important in your life. Please do not hesitate to ask questions and take advantage of the services available through the Cancer Center.

We are honored that you have chosen us to participate in your care. Thank you!

Sincerely,

The Staff of the C.R. Wood Cancer Center

Referring Physician: _____ **Specialty:** _____

Address: _____

Phone Number: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____

To better coordinate your care we would like to send a copy of our consultation note, following your visit, and any genetic tests results that you may have to the above physicians that you have listed.

Do we have your permission to send a copy of your consultation note and genetic test results to the above listed physicians?

Yes _____

No _____

Why are you seeking genetic counseling?

What is your biggest concern?

Personal Cancer History

Have you ever had a cancer diagnosis? Yes No

If yes, please complete the following (if more than one diagnosis, please list on back of this page):

Type of cancer: _____

Age at diagnosis: _____

Hospital and city where diagnosed and treated for cancer: _____

Treatment received (e.g., surgery, chemotherapy, tamoxifen, radiation, etc.) :

Previous Medical Tests/Screening

*(Please check those you have had, the most recent date it was performed, and the result.)

Mammogram Date performed: _____ Result: _____

Clinical Breast Exam Date performed: _____ Result: _____

GYN Exam Date performed: _____ Result: _____

Colonoscopy Date performed: _____ Result: _____

Skin Exam Date performed: _____ Result: _____

Past Medical History

Have you had:

Thyroid Disease no ____ yes ____ Fibrocystic breasts no ____ yes ____

Uterine fibroids no ____ yes ____ Ovarian cysts no ____ yes ____

Basal cell carcinoma no ____ yes ____ Colon polyps no ____ yes ____

Lipomas/Fibromas no ____ yes ____ (fatty tumors or skin growths)

Please describe any “yes” answers (where, when treated, etc.) below or on the back of this page.

Social History

Do you currently smoke or have you ever smoked or chewed tobacco? Yes No

If yes, how much and for how long? _____

At what age did you start? _____

If you have stopped, at what age did you stop? _____

Do you drink alcoholic beverages? Yes No If yes, approximately how many drinks per week? 4 or less 5-10 11-20 more than 20

Have you had any environmental exposures of concern? (e.g., exposed to harmful chemicals, pesticides, radiation, radon, etc?) Yes No If yes, please explain:

If applicable, Past OB/GYN History:

Age at first period: _____ Are your periods regular? Yes No

Describe _____

Have you gone through menopause? Yes No Presently occurring

Age at menopause: _____

Have you ever taken hormone replacement therapy? Yes No Uncertain

If yes, age started: _____

If applicable, age stopped (if ever taken): _____

Have you ever used oral contraceptives (birth control pills)? Yes No

If yes, total number of years used: _____

Are you currently taking oral contraceptives? Yes No

Number of pregnancies _____ Number of live births: _____ Number of still births: _____

Number of miscarriages and/or abortions: _____

Your age at the birth of your first child: _____

Have you ever had a breast biopsy? Yes No If yes, how many and what was the outcome:

Have you ever had an abnormal pap smear? Yes No If yes,

outcome _____

Have you had your uterus removed? Yes No Uncertain

If yes, at what age: _____

Have you had your ovaries removed? Yes No Uncertain

If yes at what age: _____

If applicable,

Have you had a vasectomy Yes _____ No _____

If yes, the date of your vasectomy: _____

Have you had a PSA test? Yes _____ No _____

If yes, date of last PSA test _____

Results: _____

For all patients:

Please list your current medical conditions, the treatment and any past illnesses

| Medical Condition/Illness | Date | Treatment |
|----------------------------------|-------------|------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list past surgical procedures

| Procedure and Reason | Date | Hospital Name and Location |
|-----------------------------|-------------|-----------------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

Have you, or any member of your family, received genetic testing in the past?

****If yes: please provide a copy of your/family test report for preparation of appointment ****

Any additional personal, social, medical history that you feel is important for us to know in preparation of your appointment:

Family History

Your immediate family (Please list only those related to you through blood. If additional space is needed, please write on back of this page.)

*Please indicate if any of your brothers or sisters are half-siblings and through whom (mom or dad) you are related.

| Names | Current Age | Age at death | Cause of Death | If affected with cancer, list type(s) and treatment (if known) | Age at cancer diagnosis | Number of children | Any children with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis. |
|-------------------------|-------------|--------------|----------------|--|-------------------------|--------------------|--|
| Your Mother | | | | | | | |
| Your Father | | | | | | | |
| Your brothers & sisters | | | | | | #Male #Female | |
| 1. | | | | | | #Male #Female | |
| 2. | | | | | | #Male #Female | |
| 3. | | | | | | #Male #Female | |
| 4. | | | | | | #Male #Female | |
| 5. | | | | | | #Male #Female | |
| 6. | | | | | | #Male #Female | |

Your Children

*If you had children with different partners please indicate this next to your child's name. (Please do not include adopted children or step children who are not related to you through blood. If additional space is needed, please write on back of this page.)

| Names | Current Age | Age at death | Cause of Death | If affected with cancer, list type(s) and treatment (if known) | Age at cancer diagnosis | Number of children | Any children with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis. |
|---------------|--------------------|---------------------|-----------------------|---|--------------------------------|---------------------------|---|
| Your Children | | | | | | #Male | |
| 1. | | | | | | #Female | |
| | | | | | | #Male | |
| 2. | | | | | | #Female | |
| | | | | | | #Male | |
| 3. | | | | | | #Female | |
| | | | | | | #Male | |
| 4. | | | | | | #Female | |
| | | | | | | #Male | |
| 5. | | | | | | #Female | |
| | | | | | | #Male | |
| 6. | | | | | | #Female | |
| | | | | | | #Male | |
| 7. | | | | | | #Female | |
| | | | | | | #Male | |
| 8. | | | | | | #Female | |

Your Mother's family

Your Mother's family (Please list only those related to you through blood, not through marriage. If additional space is needed, please write on back of this page.)

List the countries/parts of the world your Mother's family is from: _____

List the religious background of your Mother's family: _____

| Names | Current Age | Age at death | Cause of Death | If affected with cancer, list type(s) and treatment (if known) | Age at cancer diagnosis | Number of children | Any children with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis. |
|--|-------------|--------------|----------------|--|-------------------------|--------------------|--|
| Your Maternal Grandmother (Mother's Mother) | | | | | | / | / |
| Your Maternal Grandfather (Mother's Father) | | | | | | / | / |
| Your Maternal Aunts/Uncles (Mother's Brothers & Sisters) 1. | | | | | | #Male #Female | |
| 2. | | | | | | #Male #Female | |
| 3. | | | | | | #Male #Female | |
| 4. | | | | | | #Male #Female | |
| 5. | | | | | | #Male #Female | |
| 6. | | | | | | #Male #Female | |

Your Father's Family

Your Father's Family (Please list only those related to you through blood, not through marriage. If additional space is needed, please write on back of this page.)

List the countries/parts of the world your Father's family is from: _____

List the religious background of your Father's family: _____

| Names | Current Age | Age at death | Cause of death | If affected with cancer, list type(s) and treatment (if known) | Age at cancer diagnosis | Number of children | Any with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis. |
|--|-------------|--------------|----------------|--|-------------------------|--------------------|---|
| Your Paternal Grandmother (Father's Mother) | | | | | | | |
| Your Paternal Grandfather (Father's Father) | | | | | | | |
| Your Paternal Aunts/Uncles (Father's Brothers & Sisters) | | | | | | #Male #Female | |
| 1. | | | | | | #Male #Female | |
| 2. | | | | | | #Male #Female | |
| 3. | | | | | | #Male #Female | |
| 4. | | | | | | #Male #Female | |
| 5. | | | | | | #Male #Female | |
| 6. | | | | | | #Male #Female | |

Other family members who have had cancer (e.g., great aunts or great uncles, second cousins, cousins once-removed. If additional space is needed, please write on back of this page.)

| List relationship to you and name | Current Age | Age at death | Cause of Death | If affected with cancer, list type and treatment (if known) | Number Of Children | Age at cancer diagnosis | Any with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis. |
|-----------------------------------|-------------|--------------|----------------|---|--------------------|-------------------------|---|
| 1. | | | | | #Male #Female | | |
| 2. | | | | | #Male #Female | | |
| 3. | | | | | #Male #Female | | |
| 4. | | | | | #Male #Female | | |
| 5. | | | | | #Male #Female | | |
| 6. | | | | | #Male #Female | | |
| 7. | | | | | #Male #Female | | |
| 8. | | | | | #Male #Female | | |
| 9. | | | | | #Male #Female | | |