Genetic Risk Evaluation and Testing Program
Southern Cancer Center

Personal and Family History Questionnaire

Please fill out this packet as accurately as you can and return it to the nearest Southern Cancer Center clinic or bring it with you to your visit.

If you have questions, patients being seen in Mobile or Baldwin County may call (251) 625-6896, and patients being seen in Huntsville may call (256) 265-1822.

Date:_______________________________________

Name: _______________________________________ Date of Birth:_________________________

Referring Healthcare Provider:____

Reason for referral: ____

Gender at birth: Female / Male Gender identity: Female/Male/transgender/___________

Are you adopted? YES NO Are you a twin? YES NO, if yes -are you identical or fraternal? Circle one

Ancestry: Please select all that apply

Mother's Side

☐ Western/Northern European ☐ Jewish
☐ Central/Eastern European ☐ African
☐ Middle Eastern ☐ Asian
☐ Latin American/Caribbean ☐ Native American

Father's Side

☐ Western/Northern European ☐ Jewish
☐ Central/Eastern European ☐ African
☐ Middle Eastern ☐ Asian
☐ Latin American/Caribbean ☐ Native American

Please list any *hereditary cancer genetic testing* you or your family members have had.
If a family member has previously been tested, please obtain a copy of their results. A copy of results will be needed in order for you to proceed with testing for any known mutation in the family. It is helpful to obtain all family members genetic reports even if negative:

____

____

Note: If you have death certificates or pathology reports on family members with cancer or pre-cancer, please include with packet

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Your Personal Health History

Cancer history:

- Do you have a current or past diagnosis of cancer? YES NO

  If the answer is yes, please answer these questions, if no then proceed to endoscopy history.

  What type of cancer?____

  What age were you when you were diagnosed?_______________

  What treatments did you receive for this cancer? (surgery, radiation, chemotherapy, hormonal)

  ____

  Have you ever had any other cancers, either current or past? YES NO

  Please list type and age(s) at diagnosis:

  ____

  ____

Endoscopy history:

- Have you ever had a colonoscopy? YES NO
- Age at first colonoscopy____________Date of last colonoscopy____________

  Have you ever had Colon Polyps? YES NO

  Age at first colon Polyp _________ Total Number of colon Polyps _________

  Type of Polyp (If known) _________________________
- Have you ever had an upper endoscopy? YES NO

Habits/Social history

Have you ever smoked? YES NO. If Yes, How many packs per day_______

Age started______Age stopped______

Do you drink alcohol? YES NO. If Yes, How many drinks per week? ______

Occupation:____Retired? YES/NO

Relationships: Single/Significant other/ Partnered/Married/________________ circle or fill in the blank

For Women:

Age periods started?______Age at Menopause?_______Circle one: Surgical/Cancer treatment/Natural

#of pregnancies________#of live births____________Number of C-sections _______

At what age did you have your first child?__________Did you breast feed for longer than 1 month? YES NO

History of abnormal pap smears? YES NO Age if yes _________

Have you ever taken hormones for menopause? YES NO Type________________How long? __________

Have you ever taken oral contraceptives? YES NO Total # years taken __________

Date (Month/Year) of most recent mammogram _____________

Have you ever had a breast biopsy? YES NO # of biopsies_________

Was your biopsy normal or abnormal?_____________Check here if Unknown _______

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1. Please List surgeries and year surgery completed:

Surgery	Year of surgery

2. Please list any medical history

Condition	Year diagnosed

3. Please list any allergies to medications:

____

4. Please list medications:

Medication	Dosage	Frequency

Personal and Family History Questionnaire

This next section is about your PARENTS and GRANDPARENTS - please list all biological relatives including relatives without a history of cancer

Parents and Grandparents	First Name	Living? Circle one	Cancer YES NO circle one Type: list type if Yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Mother		YES NO	YES NO Type:		
Your Mother's Mother		YES NO	YES NO Type:		
Your Mother's Father		YES NO	YES NO Type:		
Father		YES NO	YES NO Type:		
Your Father's Mother		YES NO	YES NO Type:		
Your Father's Father		YES NO	YES NO Type:		

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This next section is about your CHILDREN- please list all biological children including those without a history of cancer

Please indicate if any of your children are twins. Please note if they are identical twins or fraternal twins. If your child is adopted, please specify if they are related to someone else in the family.

Your Biological Children	First Name	Living? Circle one	Cancer YES NO circle one Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And #daughters Your child has -Use 0 if none
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:

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Personal and Family History Questionnaire

This next section is about your SIBLINGS - please list all biological siblings including those without a history of cancer

Your Siblings: How many full sisters_______How many full brothers________
How many half- sisters_______How many half -brothers _______
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, circle shared parent	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And # daughters each sibling has -Use 0 if none
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:

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This next section is about your MOTHER'S SIBLINGS - please list all biological aunts and uncles including those without a history of cancer

Your Mother's siblings:

How many full sisters____________and brothers____________does your mother have?

How many half- sisters_______How many half -brothers ______

Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, circle shared parent	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters each relative has. -Use 0 if none
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:

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List **your *first* Cousins** on your **MOTHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer**.

Circle gender and write first Name of each	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

Add any additional maternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known

Circle gender and write first Name of each	How are they related to you? (Ex: Mother's maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

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This next section is about your FATHER'S SIBLINGS - please list ALL biological aunts and uncles including those without a history of cancer

Your father's siblings:
How many full sisters____________and brothers____________does your father have?
How many half- sisters_______How many half -brothers ______
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, circle shared parent	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters Each relative has. -Use 0 if none
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:

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List **your *first* Cousins** on your **FATHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer**.					
Circle gender and write first Name of each	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

Add any additional paternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known					
Circle gender and write first Name of each	How are they related to you? (Ex: fathers, maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		