

Stanford Cancer Genetics Clinic

Personal and Family History Questionnaire

It is very important for you to complete this form to the best of your ability and return it to us well in advance of your scheduled appointment. This allows us appropriate time to prepare, so that the consultation is as beneficial as possible. You may also receive a brief phone call from our clinic to clarify or gather additional information.

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 (Maiden)

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

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

Ethnicity: African American/Black Asian Caucasian/White Hispanic Jewish (Ashkenazi) Other _____

Paternal Countries of Origin (i.e. Irish, German, Italian, African, etc.): _____

Maternal Countries of Origin (i.e. Irish, German, Italian, African, etc.): _____

Females Only:

Age at menarche (first period): _____ Number of years on birth control pills: _____

How many times have you been pregnant: _____ Age at birth of first child: _____

Number of years breast feeding: _____ Number of years on hormone replacement therapy: _____

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 Both

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

Have you had an oophorectomy (surgical removal of the ovaries)? No One Both

Have you ever taken Tamoxifen (to treat or prevent breast cancer)? Yes No

Female & Males:

Smoking history?: Never Previous Smoker: # years? _____ Quit in what year? _____

Current Smoker: 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)? _____

Your Cancer History:

Type(s) of Cancer: _____

Age(s) at Diagnosis: _____

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

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)					
If half-sibling, please denote maternal-half or paternal-half	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			

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	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 2	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 3	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 4	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 5	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 6	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 7	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> deceased			
Niece / Nephew 8	<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)

	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)					
Name (First, Last (Maiden))	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 BLOOD RELATIVES					
List anyone else with cancer such as your 1 st & 2 nd cousins and grandparents' siblings					
Denote Relationship (i.e. first cousin, etc.) and circle M for maternal or P for paternal	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			

RETURN ADDRESS:

Stanford Cancer Genetics Clinic
 900 Blake Wilbur Dr. – Floor 3
 Stanford, CA 94305

Or Fax the completed form to 650-498-5150