

Hereditary Cancer Program Questionnaire:

Please provide the following information regarding your personal health and your family's health to the best of your ability. This information will be helpful to us for your upcoming clinic visit. If possible, please mail back completed forms in the envelope provided prior to your appointment or fax to (517)353-8464.

Reproductive history (women only):

1. How old were you when you had your first period? _____
2. How old were you when you had your first child? _____
3. Have you used oral contraceptives? Yes No *If yes, for how many years?* _____
3. Are you currently: Pre-menopausal post-menopausal peri-menopausal
4. Have you had a hysterectomy? Yes No *If yes, reason* _____ *age at surgery:* _____

Breast history:

5. Have you been diagnosed with breast cancer? Yes No
If yes, age at diagnosis: _____ *Was the cancer in one breast or both?* One Both
What treatment(s) did you have? mastectomy lumpectomy chemotherapy radiation
6. Have you taken Tamoxifen or Arimidex? Yes No *If yes, for how long?* _____
7. How many breast biopsies have you had? _____ *Results:* _____
Age at first biopsy? _____
8. Have you had your breasts surgically removed for any reason? Yes No
If yes, reason _____
9. How often do you do the following:
Self-breast exams: _____ Mammograms: _____ Other: _____
Clinical breast exams: _____ Breast MRI: _____
10. When was your most recent:
Self-breast exams: _____ Mammograms: _____ Other: _____
Clinical breast exams: _____ Breast MRI: _____

Ovarian history (women only):

11. Have you had ovarian cancer? Yes No *If yes, age at diagnosis?* _____
12. Have you had your ovaries surgically removed for any reason? Yes No
If yes, at what age and why? _____
13. How often do you have the following:
CA-125 levels: _____ Transvaginal ultrasound: _____ Pelvic exam: _____

Colon history:

14. Have you been diagnosed with colon cancer? Yes No

If yes, age at diagnosis: _____

16. Have you had your colon surgically removed for any reason? Yes No

17. How often do you have the following:

Fecal occult blood test: _____ Sigmoidoscopy: _____ Colonoscopy: _____

18. When was your most recent:

Fecal occult blood test: _____ Sigmoidoscopy: _____ Colonoscopy: _____

Other history:

20. Have you been diagnosed with any other types of cancer? Yes No

If yes, type of cancer _____ age at diagnosis: _____

21. Has anyone in your family had genetic testing for hereditary cancer?

If yes, who and what were the results? _____

22. What is your ethnic background?

- African American Asian Caucasian (non-Jewish)
 Jewish Hispanic Other, please specify

23. Please indicate if you have or have had any of the following:

Thyroid disease: Yes No *If yes, please describe: _____ age at diagnosis: _____*

Fibrocystic breasts: Yes No

Ovarian cysts: Yes No

Uterine fibroids: Yes No

Colon polyps: Yes No *If yes, age at diagnosis: _____ number of polyps: _____*

Other medical problems:

Please list any specific questions or concerns you have:

MICHIGAN STATE UNIVERSITY HEREDITARY CANCER CLINIC

FAMILY HISTORY FORM

PATIENT'S NAME : _____ DATE OF BIRTH: _____
 OCCUPATION: _____

I. Brothers and Sisters:

If deceased, please indicate age at death and cause.

	Age or age at death	Cancer (type, age at diagnosis) Other health problems	B. Children: Name, Age	Cancer (type, age at diagnosis) Other health problems
1. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
2. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
3. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
4. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
5. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
6. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
7. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
8. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____

Do any of the above have a different father or mother than you? If yes, who and which parent is different:

II. Your Mother

Name: _____ Maiden Name: _____
 Last First M.I.
 Date of Birth: _____

Cancer/Health: (if deceased please indicate age and cause):

III. Your Aunts and Uncles on Mother's side (Your Mother's Brothers/Sisters)

List in order of birth. If deceased, please indicate age at death and cause.

	Age or Age at Death	Cancer (type, age at diagnosis) Other health problems	B. Children: Name, Age	Cancer (type, age at diagnosis) Other health problems
1. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
2. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
3. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
4. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
5. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
6. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
7. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____
8. Male Female	Age: _____ Living Deceased		1. _____ 2. _____ 3. _____ 4. _____ 5. _____	_____ _____ _____ _____

Do any of the above have a different father or mother than the your mother? If yes, who and which parent is different:

VI. Your Grandmother on Your Mothers Side

Name: _____ Maiden Name: _____
Last First M.I.

Date of Birth: _____ Current age or age of death and cause: _____

Country of Origin or Ethnic Background: _____

Cancer/Health history:

VII. Your Grandfather on Your Mother's Side

Name: _____
Last First M.I.

Date of Birth: _____ Current age or age of death and cause: _____

Country of Origin or Ethnic Background: _____

Cancer/Health history:

VIII. Your Grandmother on Your Father's Side

Name: _____ Maiden Name: _____
Last First M.I.

Date of Birth: _____ Current age or age of death and cause: _____

Country of Origin or Ethnic Background: _____

Cancer/health history:

IX. Your Grandfather on Your Father's Side

Name: _____
Last First M.I.

Date of Birth: _____ Date of Death and cause: _____

Country of Origin or Ethnic Background: _____

Cancer/Health history:

X. Additional information or comments (please include any other family members with cancer):