METRO HEALTH
UNIVERSITY OF MICHIGAN HEALTH

Dear Patient,

You have been referred to the Genetics Clinic for further evaluation of a potential hereditary cancer syndrome. This means you have a known genetic condition in the family, **OR** you have been diagnosed with a type of cancer that is commonly associated with a genetic disorder.

At this 90 minute visit we will:

- Evaluate your personal and family health history.
- Perform a comprehensive risk assessment for familial and heritable cancer syndromes.
- Discuss benefits and limitations of genetic testing.
- Consider outcomes of possible test results and potential risk management options.
- Draw blood for genetic testing if indicated.
- Assess insurance coverage and financial implications.
- Review protections in place provided by the Genetic Information Nondiscrimination Act (GINA).

To prepare for your appointment we need to collect some additional information about your personal and family health history. Please complete the following questionnaire to the best of your ability and return it to the clinic using the **enclosed pre-paid envelope**.

Once this information is received, we will contact you by phone to schedule a genetic counseling appointment. Please do not hesitate to contact the office with further questions or concerns.

We look forward to meeting you!

Cheryl VanStraten, NP-BC

Metro Health Cancer Center
5950 Metro Way SW | Wyoming, MI 49519
616.252.8100 | metrohealt.net

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FAMILY HISTORY QUESTIONNAIRE

Instructions: This questionnaire will gather information about the history of cancer in your family. Data collected will be used by the Metro Health – University of Michigan Health Cancer Genetics Clinic to help assess your risk of developing cancer and decide if the cancers in your family are related to an inherited gene.

Please complete to the best of your ability. When filling out this form, only consider family members related to you by blood, such as your parents, grandparents, children, siblings, aunts, uncles and cousins. If you only have one parent in common with a sibling, please make a note of this. Do not include information about adopted, foster, or step-relatives.

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ABOUT YOU:

Date: _____

Late Name:_____First:_____M.I._____

Address: _____

Date of Birth: _____ Phone: ( )_____

Last 4 digits of your SSN:_____

Sex M ☐ F ☐ Race: (for Cancer Research Only) _____

Primary Physician:_____ Referring Physician:_____

Surgeon:_____Other:_____

Gender: _____

Age: _____

Race: _____

Mother's Ancestry (i.e. German, African American): _____

Father's Ancestry: _____

Do either of your parents have any Ashkenazi (Eastern European) Jewish ancestors that you are aware of? (Eastern European ancestry is a factor in determining hereditary cancer risk.)

_____

Do you have any related family members (i.e. first cousins) that have married each other? _____

Please indicate if you have or ever have had the following:

- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis (TB)
- ☐ Thyroid Problems
- ☐ High Blood Pressure
- ☐ Heart Attack / Heart Disease
- ☐ Irregular Heart Rhythm
- ☐ Rheumatic Fever
- ☐ Blood Clots
- ☐ Anemia or a Blood Disorder
- ☐ Blood Transfusion(s) (if yes) When_____
- ☐ History of Pneumonia (if yes) When_____
- ☐ Stroke / TIA
- ☐ Seizures
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Hepatitis / Jaundice
- ☐ Diverticulosis / Colon Problems
- ☐ Ulcers
- ☐ Previous Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Depression

Please list previous operations, year and where they took place:

Year	Operation and Where

PERSONAL MEDICAL HISTORY:

Have you ever had cancer? *(If yes, provide cancer type and age of diagnosis)* _____

_____

_____

Have you ever had genetic testing for cancer? *(If yes, please include a copy of test results)* _____

_____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced No. of Children _____

Occupation: _____

Do you smoke? ☐ Yes ☐ No Amount per day:_____ How many years:_____

Have you ever smoked? ☐ Yes ☐ No Amount per day:_____ Quit Date:_____

Do you use chewing tobacco? ☐ Yes ☐ No Amount per day:_____ How many years:_____

Have you ever used chewing tobacco? ☐ Yes ☐ No Amount per day:_____

How many years:_____Quit Date:_____

Do you drink alcohol? ☐ Yes ☐ No Type: Beer/Wine amount per week:_____

Liquor amount per week:_____

Do you or have you ever used recreational drugs? ☐ Yes ☐ No What kind:_____

MEN'S HEALTH HISTORY:

Have you begun prostate cancer screening? _____

Date of last PSA: _____

Date of last prostate exam:_____

Have you ever had an elevated PSA level?_____

WOMEN'S HEALTH HISTORY:

Date of your last menstrual period _____ / _____ /_____

Are you using birth control? ☐ Yes ☐ No Is there any chance you are pregnant? ☐ Yes ☐ No

Number of Pregnancies:_____ Number of Births:_____

Number of Abortions:_____ Number of Miscarriages:_____

What age did you start menstruating?_____

Are you menopausal? ☐ Yes ☐ Age of onset of menopause:_____

Last PAP / Pelvic GYN exam: _____ / _____ /_____ ☐ Normal ☐ Abnormal Where?_____

Last Mammogram: _____ / _____ /_____ ☐ Normal ☐ Abnormal Where?_____

Do you have a personal history of infertility? _____

Age at first birth: _____

Are you currently using oral contraceptives? _____

Have you used oral contraceptives in the past? _____

What is the total length of time you have used oral contraceptives? _____

Please list other hormonal methods of birth control you have used: _____

_____

Have you had a hysterectomy? If yes, at what age? Were your ovaries removed?

_____

Are you currently or have you previously used hormone replacement therapy?_____

What is the total length of time you have been on hormonal therapy?_____

Number of past breast biopsies: _____

OTHER CANCER SCREENING HISTORY:

Have you have had one of the following examinations:
(please indicate the approximate year they occurred and any known findings)

Colonoscopy _____

Upper endoscopy _____

Flexible sigmoidoscopy _____

Barium enema _____

Stool blood test _____

Do you have any history of colon polyps? When were they detected?

_____

If yes, approximate number of polyps:

Type of polyps: _____

HAVE ANY OF YOUR RELATIVES HAD GENETIC TESTING?

If yes, please complete the following table.

Name	Relationship to patient	Condition tested	Laboratory	Result

If you have a family history of breast cancer, please indicate if the breast cancer was unilateral or bilateral (i.e. left breast or both breasts) in the affected individual.

_____

For relatives who developed a second cancer, did the second cancer arise as a new unrelated cancer? Or did it result from spread of the first cancer.

_____

YOUR FAMILY HISTORY:

Do you have children?_____

If yes, please complete the following table:

Name (children)	Gender	Current age	Age of death (as appropriate)

Do you have **siblings** that you share both a mother and father with?_____
If yes, please complete the following table:

Name (brothers & sisters)	Gender	Current age	Age of death (as appropriate)	Your brothers' & sisters' children
				# of sons: Ages: # of daughters: Ages:
				# of sons: Ages: # of daughters: Ages:
				# of sons: Ages: # of daughters: Ages:

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Do you have any **half-siblings** that you only share one parent with?_____
If yes, please complete the following table and clarify which parent is shared:

Name (brothers & sisters)	Gender	Current age	Age of death (as appropriate)	Your brothers' & sisters' children
				# of sons: Ages: # of daughters: Ages:
				# of sons: Ages: # of daughters: Ages:
				# of sons: Ages: # of daughters: Ages:

YOUR MOTHER'S FAMILY:

Name	Gender	Current age	Age of death (as appropriate)	Your Aunts' & Uncles' children
Your Mother				
Your Mother's Father				
Your Mother's Mother				
Your Mother's Sisters				# of sons: Ages: # of daughters: Ages:
Your Mother's Brothers				# of sons: Ages: # of daughters: Ages:

YOUR FATHER'S FAMILY:

Name	Gender	Current age	Age of death (as appropriate)	Your Aunts' & Uncles' children
Your Father				
Your Father's Father				
Your Father's Mother				
Your Father's Sisters				# of sons: Ages: # of daughters: Ages:
Your Father's Brothers				# of sons: Ages: # of daughters: Ages:

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Does Cancer run in your family? Check those that apply.

Cancer Type	Yourself / Mom / Dad / Sibling / Children	Age at Diagnosis *(estimates are OK)*	Age at Diagnosis *(estimates are OK)*	Age at Death *(if deceased)*	Extended Family *(Mother's Side) Aunts / Uncles / Cousins / Grandparents*	Age at Diagnosis	Age at Death	Extended Family *(Father's Side) Aunts / Uncles / Cousins / Grandparents*	Age at Diagnosis	Age at Death
Example: ✓ Colorectal Cancer	Me	40						Aunt Jane Uncle John	68 ----	57 42
☐ Breast Cancer (in women or men)										
☐ Ovarian Cancer (peritoneal/fallopian tube										
☐ Uterine (endometrial) Cancer										
☐ Colorectal Cancer										
☐ Pancreatic Cancer										
☐ Prostate Cancer										

Continued on the next page

Does Cancer run in your family? Check those that apply.

Cancer Type	Yourself / Mom / Dad / Sibling / Children	Age at Diagnosis *(estimates are OK)*	Age at Diagnosis *(estimates are OK)*	Age at Death *(if deceased)*	Extended Family *(Mother's Side)* *Aunts / Uncles / Cousins / Grandparents*	Age at Diagnosis	Age at Death	Extended Family *(Father's Side)* *Aunts / Uncles / Cousins / Grandparents*	Age at Diagnosis	Age at Death
☐ Kidney (renal) Cancer										
☐ Melanoma										
☐ Brain Tumor Type: _____										
☐ Other Cancer Type: _____										
☐ More than 10 colorectal polyps (indicate how many)										
☐ I do not have a personal history or family history of cancer										