FAMILY HISTORY QUESTIONNAIRE

This form helps us to evaluate if you might have a higher risk of cancer because of your family history. Please complete this form to the best of your ability. If you are unsure of any information, please provide your "best guess" and indicate whether or not you can obtain more details. If you have difficulty completing the questionnaire and or wish to discuss the referral, please contact us at the number below.

PLEASE RETURN THE COMPLETED FORM TO:
Hereditary Cancer Program, Genetics Clinic
Children's Hospital of Eastern Ontario
401 Smyth Road, Ottawa, ON K1H 8L1
Phone (613) 737-7600 ext. 2603 Fax (613) 738-4822

SOME HELPFUL HINTS FOR FILLING OUT THIS QUESTIONNAIRE:

- When filling out this questionnaire, please complete both sides
- When listing the name of any relative, please be sure to include both the last name and maiden name (in brackets)
- If there is not enough space for all relatives to be listed, please list answers on a separate sheet of paper
- Please include all blood relatives, whether or not they have had cancer. **The last page will ask about specific information on your relatives with cancer.**
- If there are any half-brothers or half-sisters, please indicate whether they have the same mother or father as the person in question.
- You may wish to consult other family members, if necessary, to obtain the most accurate information.

YOUR NAME			TODAY'S DATE	
DATE OF BIRTH			HEALTH CARD NUMBER	
FAMILY DOCTOR			REFERRING DOCTOR	
YOUR ADDRESS				
YOUR PHONE NUMBERS	WORK		HOME	

PATIENT NAME:________________________________

YOUR FAMILY HISTORY

Have you ever been diagnosed with any type of cancer?	YES		NO	

If YES, please describe type, treatment, and hospital		
Type of Cancer Treatment	Date of Diagnosis	Hospital and City

What is your family's ethnic background? (e.g., Aboriginal, English, Ashkenazi Jewish, etc.)	
Mother's mother	
Mother's father	
Father's mother	
Father's father	

Has anyone in your family previously been referred for genetic counseling and/genetic testing?	YES		NO		UNSURE	

If yes, please state where:	

PATIENT NAME:______________________________

YOUR CHILDREN

Full Name	Sex (M/F)	Date of Birth (yy/mm/dd)	If deceased, age and cause of death	# of children Ex. 2 M, 1F

YOUR BROTHERS AND SISTERS

Full Name	Sex (M/F)	Date of Birth (yy/mm/dd)	If deceased, age and cause of death	# of children Ex. 2 M, 1F

PATIENT NAME:____

YOUR MOTHER'S FAMILY

YOUR MOTHER'S FULL NAME		DATE OF BIRTH (yy/mm/dd)	
MAIDEN NAME			
IF DECEASED, GIVE AGE AND CAUSE OF DEATH			
NAME OF YOUR MOTHER'S MOTHER *(MATERNAL GRANDMOTHER*)		DATE OF BIRTH (yy/mm/dd)	
IF DECEASED, GIVE AGE AND CAUSE OF DEATH			
NAME OF YOUR MOTHER'S FATHER *(MATERNAL GRANDFATHER)*		DATE OF BIRTH (yy/mm/dd)	
IF DECEASED, GIVE AGE AND CAUSE OF DEATH			

YOUR MOTHER'S SIBLINGS				
Full Name	Sex (M/F)	Date of Birth (yy/mm/dd)	If deceased, age and cause of death	# of children Ex. 2 M, 1F

PATIENT NAME:________________________________

YOUR FATHER'S FAMILY

YOUR FATHER'S FULL NAME		DATE OF BIRTH (yy/mm/dd)	
IF DECEASED, GIVE AGE AND CAUSE OF DEATH			
NAME OF YOUR FATHER'S MOTHER *(PATERNAL GRANDMOTHER)*		DATE OF BIRTH (yy/mm/dd)	
IF DECEASED, GIVE AGE AND CAUSE OF DEATH			
NAME OF YOUR FATHER'S FATHER *(PATERNAL GRANDFATHER)*		DATE OF BIRTH (yy/mm/dd)	
IF DECEASED, GIVE AGE AND CAUSE OF DEATH			

YOUR FATHER'S SIBLINGS

Full Name	Sex (M/F)	Date of Birth (yy/mm/dd)	If deceased, age and cause of death	# of children Ex. 2 M, 1F

PATIENT NAME:____________________________________

YOUR RELATIVES WITH CANCER (including cousins)

YOUR BROTHERS, SISTERS, SONS, DAUGHTERS, GRANDCHILDREN, NIECES, NEPHEWS						
Name	Date of Birth (yy/mm/dd)	Relationship	Type of Cancer	Age at Diagnosis	Hospital/City where diagnosed	If deceased, date of death
YOUR MOTHER'S SIDE OF THE FAMILY (MOM, AUNTS, UNCLES, GRANDPARENTS, COUSINS, OTHER)						
Name	Date of Birth (yy/mm/dd)	Relationship	Type of Cancer	Age at Diagnosis	Hospital/City where diagnosed	If deceased, date of death
YOUR FATHER'S SIDE OF THE FAMILY (DAD, AUNTS, UNCLES, GRANDPARENTS, COUSINS, OTHER)						
Name	Date of Birth (yy/mm/dd)	Relationship	Type of Cancer	Age at Diagnosis	Hospital/City where diagnosed	If deceased, date of death