Hereditary Cancer

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 YYYY/MM/DD			HEALTH CARD NUMBER	
FAMILY DOCTOR			REFERRING DOCTOR	
YOUR ADDRESS				
YOUR PHONE NUMBERS	HOME		WORK	

Patient Name: _____

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

If YES, please describe the type , treatment and hospital

Type of Cancer	Date of Diagnosis	Hospital and City

YOUR FAMILY HISTORY	
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 counselling and/or genetic testing?	YES ☐	NO ☐	UNSURE ☐

If YES, please state where and what their genetic test results were:

Name	Location	Genetic Test Results

Patient Name: _____

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YOUR CHILDREN				
Full Name	Sex (M/F)	Date of Birth (YYYY/MM/DD)	If deceased, age and cause of death	# of children Ex. 2M, 1F

YOUR BROTHERS AND SISTERS				
Full Name	Sex (M/F)	Date of Birth (YYYY/MM/DD)	If deceased, age and cause of death	# of children Ex. 2M, 1F

Patient Name: _____

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YOUR MOTHER'S FAMILY			
Your Mother's Full Name		Date of Birth (YYYY/MM/DD)	
Maiden Name		If deceased, age and cause of death	
Your Mother's Mother (Maternal Grandmother)		Date of Birth (YYYY/MM/DD)	
Maiden Name		If deceased, age and cause of death	
Your Mother's Father (Maternal Grandfather)		Date of Birth (YYYY/MM/DD)	
Maiden Name		If deceased, age and cause of death	

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

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YOUR FATHER'S FAMILY			
Your Father's Full Name		Date of Birth (YYYY/MM/DD)	
If deceased, age and cause of death			
Your Father's Mother (Paternal Grandmother)		Date of Birth (YYYY/MM/DD)	
Maiden Name		If deceased, age and cause of death	
Your Father's Father (Paternal Grandfather)		Date of Birth (YYYY/MM/DD)	
If deceased, age and cause of death			

YOUR FATHER'S SIBLINGS				
Full Name	Sex (M/F)	Date of Birth (YYYY/MM/DD)	If deceased, age and cause of death	# of children Ex. 2M, 1F

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YOUR RELATIVES WITH CANCER (including cousins)			
YOUR BROTHERS, SISTERS, SONS, DAUGHTERS, GRANDCHILDREN, NIECES, NEPHEWS			
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:

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YOUR RELATIVES WITH CANCER (including cousins)					
YOUR MOTHER'S SIDE OF THE FAMILY (MOM, AUNTS, UNCLES, GRANDPARENTS, COUSINS, OTHER)					
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	
Name:		Date of Birth:	Relationship:		
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:		If deceased, date of death:	

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YOUR RELATIVES WITH CANCER (including cousins)			
YOUR FATHER'S SIDE OF THE FAMILY (DAD, AUNTS, UNCLES, GRANDPARENTS, COUSINS, OTHER)			
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:
Name:		Date of Birth:	Relationship:
Type of Cancer:	Age at Diagnosis:	Hospital/City where diagnosed:	If deceased, date of death:

Patient Name: ____