Health Sciences Centre Winnipeg

**Genetics File #: _____**

# Hereditary Cancer Clinic
## Family History Form

YOUR FULL NAME: _____ Daytime Phone # : _____

REFERRING PHYSICIAN: _____ PHIN: _____ BIRTHDATE: _____
month / day / year

We cannot book your appointment until we receive this form. Please complete and return it as soon as possible. The information you provide on this form will help us make the best use of your time during your appointment with Hereditary Cancer Clinic staff.

**Tips for completing this questionnaire**

- Please provide as much information as you can. The more detail you provide, the more accurate our assessment.
- You may find it helpful to contact other family members to obtain the most accurate information.
- If you do not have all the information, just do your best. Approximate ages are ok!
- If you need more space for any section, or if you wish to provide any other information that you feel is important, please attach additional pages.
- When listing the name of a family member, please include the last name and maiden name (in brackets).
- Please circle YES or NO where requested.
- Please print clearly.

**If you have any questions or are having difficulty completing this questionnaire, please contact the Hereditary Cancer Clinic at (204) 787-4267.**

Please return the completed form to:

**Hereditary Cancer Clinic**
WHRA Program of Genetics and Metabolism
FE229- Community Services Building - Health Science Centre
820 Sherbrook Street, Winnipeg, MB R3A 1R9
FAX: (204) 787-1419

## Section 1: Yourself

Have you ever had any non-cancerous change (e.g. lumps, polyps, moles)? Yes / No If Yes → Please complete table below

| Site of Non-Cancerous Change | Type of Non-Cancerous Change | Age when found | How was it found |
|---|---|---|---|
| | | | |
| | | | |

Have you ever been diagnosed with cancer? Yes / No If yes, please provide the details for each cancer diagnosis **you** have had.

| Type of cancer | Age at diagnosis | Hospital and city where treated |
|---|---|---|
| | | |
| | | |

Please complete next section only if you are **female**:

1. How old were you when you had your first period? _____ years

2. Have you ever had a baby? YES / NO
   *If YES:* How old were you when you had your first baby? ____ years
   *If NO:* (this means you have never had a baby): Have you ever been pregnant? YES / NO

3. Have you started change of life (menopause)? YES / NO
   *If YES: How* old were you when it started? _____ years

4. Have you had your uterus (womb) or ovaries removed?
   *If YES:* How old were you when your uterus or ovaries were removed? _____ years

5. Have you ever had a doctor examine a lump or mass in your breast(s)? YES / NO
   *If YES:* (a) Has a doctor ever removed a lump or examined it with a needle (biopsy)? YES / NO
   (b) Have you had more than one lump removal / biopsy? _____ number
   (c) Did your doctor ever tell you that there were atypical cells? YES / NO

## Section 2: Background information

Are you adopted? Yes / No

If yes, please complete this questionnaire to the best of your ability for blood (biological) relatives only. If you do not have any information about your blood (biological) relatives, please contact our clinic as you may not need to complete the rest of this questionnaire.

Has anyone in your family had genetic counselling or genetic testing for the family history of cancer? Yes / No

If yes, please contact our clinic as you may not need to complete the rest of this questionnaire.

(If more than one family member has seen genetics please provide information below for each on separate sheet)

Name of family member(s): _____ Relationship to you: _____

Location of the genetics clinic: _____

Hospital City Province

## Section 3: Your family

Do you have children? Yes or No If yes, how many boys_____ and how many girls_____? What is their age range? _____

Do you have any full siblings? Yes or No If yes, how many brothers _____and how many sisters_____? What is their age range? _____

Do you have any half siblings? Yes or No If yes how many brothers _____ and how many sisters_____ with the same mom as you?

If yes how many brothers _____ and how many sisters_____ with the same dad as you?

| Your | Full Name | Current age (if alive) | If deceased, age and cause of death | # of their siblings | |
|---|---|---|---|---|---|
| | | | | Male | Female |
| Mother | | | | | |
| Father | | | | | |

What is your family's ethnic background: (e.g. Aboriginal, African Canadian, English, French, Jewish, German, Irish, Icelandic. etc)

Mother's side: _____ Father's side: _____

## Section 4: Family members with cancer

Please list **all family members affected with cancer**, even if they have been listed in previous sections. Only include those who are related to you by blood. Remember to include any who are deceased.

When listing the **type of cancer**:

- Please indicate where the cancer started. e.g. breast cancer that spreads to the lung should be identified as breast cancer.
- If the cancer is gynecologic (i.e. woman's cancer), please state if it was in ovary, uterus or cervix. If unsure, put gynecologic cancer.
- If primary cancer site is unknown, please put unknown.

| Full Name | Relationship to you (include side of the family) | Date of Birth | Type of cancer | Age at diagnosis | Year diagnosed | Hospital and/or city where treated | Living (Y / N) |
|---|---|---|---|---|---|---|---|
| *e.g. John Doe* | *cousin (mother's brother's son)* | *14/Mar/64* | *colon* | *early 40's* | *~ 2000* | *Cross Cancer, Edmonton* | *Y* |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Thank you for taking the time to complete this questionnaire!**