

Cancer Genetics Risk Assessment Program

Medical and Family History Questionnaire

St. Vincent Hospital Center for Cancer Care
8301 Harcourt Rd.#100 /Indianapolis, IN 46260
Appointments: (317) 415-RISK (7475)

Please complete and fax to (317) 415-6675 or bring to your appointment.

Name _____ Date of birth _____

Contact info (check preferred method to be contacted): Home phone _____

Work phone _____ Cell phone _____ Email: _____

Support person _____ Relationship to you _____

With whom in the family may we discuss medical information about you?

Name _____ Phone # _____

Name _____ Phone # _____

Name _____ Phone # _____

Have other members of your family been patients in this clinic? Yes No

If yes, please list name and relationship: _____

Has anyone in your family had genetic testing for cancer predisposition? Yes No

If yes, please list the relationship of the individual, their test results, and the location where genetic testing was performed: _____

Medical History

Have you ever had cancer? Yes No

➤ If yes:

• Type(s): _____

• Age of onset: _____

• How treated? Surgery Chemotherapy Radiation

• If breast cancer: Lumpectomy Mastectomy - Left Right Bilateral

Are you taking or have you ever taken Tamoxifen and/or an aromatase inhibitor? Yes No

Estrogen receptor status: ER positive negative

PR positive negative

Her2 positive negative

Name: _____

Have you ever had a breast biopsy? Yes No

➤ If yes:

- How many and what was the outcome, if known? _____
- When and where were the biopsy(ies) performed? _____

Do you or have you ever had:

Thyroid disease Yes No Fibrocystic breasts Yes No
Uterine fibroids Yes No Colon polyps Yes No total # ever found _____
Lipomas/Fibromas (fatty tumors or skin growths) Yes No

Screening (Please check those you have had, the most recent date it was performed, and the result):

<input type="checkbox"/> Mammogram	Date: _____	Result: _____
<input type="checkbox"/> Breast MRI	Date: _____	Result: _____
<input type="checkbox"/> Pap and pelvic exam	Date: _____	Result: _____
<input type="checkbox"/> Transvaginal Ultrasound	Date: _____	Result: _____
<input type="checkbox"/> CA-125	Date: _____	Result: _____
<input type="checkbox"/> Colonoscopy	Date: _____	Result: _____
<input type="checkbox"/> PSA	Date: _____	Result: _____

Do you smoke or have you ever smoked? Yes No

If yes, for how many years? _____

If currently smoking, approximately how many cigarettes in a single day?

½ pack or less ½ to 1 pack 1-2 packs more than 2 packs

Approximately how many alcoholic beverages do you drink per week?

0-5 6-10 11-20 more than 20

Have you ever been exposed to chemicals, radiation, etc. ? Yes No

If yes, please explain: _____

How much do you exercise (cardiovascular) in a week?

0-30 minutes 30-60 minutes 1-2 hours more than 2 hours

Please list any chronic conditions (use back side if need more room):

Medical Condition/Illness	Date	Treatment

Name: _____

Please list any surgeries you've had (use back side if need more room):

Surgical Procedure and Reason	Date	Hospital Name and Location

Please list current medications (use back side if need more room):

Name of Medication	Reason for Taking Medication

If female, please answer the following:

Age at first period _____ Age at last period _____

➤ If periods have stopped, why?

naturally hysterectomy radiation chemotherapy

Have you ever used birth control pills? Yes No

➤ If yes, for how long? <1 year 1-5 years 5-10 years 10-15 years >15 years

Have you ever used postmenopausal hormones? Yes No

➤ If yes, list which ones, when and for how long:

Number of pregnancies: _____ Number of children: _____ Age at first full term pregnancy: _____

Did you breastfeed? Yes No

If yes, for how long (total, including all children)?

Never <1 year 1-2 years 2-3 years 3-4 years 4-5 years >5 years

Do you have a gynecologist? Yes No

➤ If yes, name: _____

Please check if you have had surgery to remove, and reason why:

	Breast (which one)	
	Ovary	
	Uterus	
	Cervix	
	Total hysterectomy	
	Other (please list)	

Name: _____

Please check your primary reason for coming for this genetic consultation (check all that apply):

- Personal risk for cancer
- Family risk for cancer (e.g. children, sibs, etc.)
- Genetic testing
- Risk reduction options: chemoprevention (e.g. Tamoxifen), preventative surgery
- Screening Recommendations
- No concerns, my doctor recommended this consultation
- Other _____

How did you learn about our program?

Family History

On the following pages, please record the information about your family members on the family history grid provided, listing each by their first and last name, even if they have never had cancer (in this case, write N/A). Please be as specific and accurate as possible. Consulting other family members may be helpful in completing this form. If you need more space, please use additional paper.

Name	Date of birth	Cancer type(s)	Age(s) at diagnosis	Where diagnosed and by whom?	Was the cancer on both sides?	If deceased, age & cause of death
------	---------------	----------------	---------------------	------------------------------	-------------------------------	-----------------------------------

You						
<input type="checkbox"/>						
Your brothers & sisters						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
Your children						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						

Name: _____

Name	Date of birth	Cancer type(s)	Age(s) at diagnosis	Where diagnosed and by whom?	Was the cancer on both sides?	If deceased, age & cause of death
------	---------------	----------------	---------------------	------------------------------	-------------------------------	-----------------------------------

Your mother						
<input type="checkbox"/>						
Brothers & sisters of your mother						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
Your mother's mother						
<input type="checkbox"/>						
Your mother's father						
<input type="checkbox"/>						

Name: _____

Name	Date of birth	Cancer type(s)	Age(s) at diagnosis	Where diagnosed and by whom?	Was the cancer on both sides?	If deceased, age & cause of death
------	---------------	----------------	---------------------	------------------------------	-------------------------------	-----------------------------------

Your father						
<input type="checkbox"/>						
Brothers & sisters of your father						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
<input type="checkbox"/>						
Your father's mother						
<input type="checkbox"/>						
Your father's father						
<input type="checkbox"/>						
Others with cancer (pls list relationship, i.e., niece, grandchild, etc)						
<input type="checkbox"/>						
<input type="checkbox"/>						

Name: _____