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NAME:
DOB:
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Cancer Genetics Program Questionnaire

Please fill out this form as completely as possible so that we may prepare for your visit. The focus will be on the history of cancer. The first part of the questionnaire is about your personal medical history. The second part is about your family history.

- If you are uncertain about any information, please write in your best approximation or write unknown.
- You may decline to answer any or all of the questions.
- Please try to gather as much of your family history information as possible before your appointment.
- Names of family members are used only as a reference and to reduce our errors; we will not contact your family members.
- After completing the questionnaire you may wish to keep a copy for your records.

You can return your questionnaire, and any other requested records, by email to CancerGenetics@mednet.ucla.edu, or by fax to 310-825-5136. If you have any questions or concerns, please call our genetic counseling assistants at 310-267-0917.

Date:_____

Name:_____ DOB: _____ Age: _____

Please list your healthcare providers below and check the box next to the provider's name if you would like us to send them a copy of your genetics evaluation.

	Name	Type	Contact / Address
☐		○ Primary ○ Surgeon ○ Medical Oncologist ○ Other:	
☐		○ Primary ○ Surgeon ○ Medical Oncologist ○ Other:	
☐		○ Primary ○ Surgeon ○ Medical Oncologist ○ Other:	

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Family Ancestry

Please indicate the ethnic/racial background that best describes you and your biological parents. (Check all that apply)

Self	Mother	Father	
☐	☐	☐	White or Caucasian
☐	☐	☐	Black or African-American
☐	☐	☐	Native American – Tribal affiliation if known:
☐	☐	☐	Asian
☐	☐	☐	Hispanic or Latino
☐	☐	☐	Ashkenazi (Easter/Central European) Jewish
☐	☐	☐	Middle Eastern
☐	☐	☐	Other:

What is your ethnic/geographic origin? (For example, "Irish" or "Mexican")

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

Genetic testing history

Have you ever had genetic testing for hereditary cancer? ◯Yes ◯No

If yes, please describe: _____

Please submit a copy of your genetic test results to our office along with your completed questionnaire.

Has anyone in your family ever had genetic testing for hereditary cancer? ◯Yes ◯No

If yes, please describe: _____

A copy of your relative's genetic test result is very important for a complete assessment. Please contact your relative(s) and ask for a copy to submit to our office along with your completed questionnaire.

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Personal History

Sex assigned at birth:_____ Height: _____ Weight:_____

Have you ever been diagnosed with cancer? ◯ **Yes** ◯ **No**			
Date of diagnosis	**Age at diagnosis**	**Type/site of cancer**	**Treatment (check all that apply)**
			□ Surgery □ Chemotherapy □ Radiation □ Bone marrow transplant □ other:_____
			□ Surgery □ Chemotherapy □ Radiation □ Bone marrow transplant □ other:_____
			□ Surgery □ Chemotherapy □ Radiation □ Bone marrow transplant □ other:_____

Do you have any serious or chronic illnesses other than cancer? If so, please specify:

_____

_____

Have you ever had any colon polyps? If yes, at what age were they first found? ____
Please describe (type and number) if possible:

_____

_____

Have you had any previous breast biopsies? □ **Yes** □ **No**		
Date	Side	Outcome
	□ Right □ Left	
	□ Right □ Left	
	□ Right □ Left	

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Gynecologic History (if your sex assigned at birth is female)

How old were you when you got your first period? _____

Have you gone through menopause? □ Yes □ No If yes, at what age? _____

How many pregnancies have you had? _____ How many live births have you had? _____

How old were you when your first child was born? _____ Did you breastfeed? □ Yes □ No

Have you ever taken hormone replacement therapy (HRT)? □ Yes □ No

If yes, date started: _____ Date stopped: _____ Type: _____

Have you ever used birth control pills? □ Yes □ No If yes, for how long? _____

Have you had a hysterectomy (surgery to remove your uterus)?
□ Yes □ No If yes, at what age? _____ Reason: _____

Have you had a oophorectomy (surgery to remove your ovaries)?
□ Yes □ No If yes, at what age? ____ Reason: _____

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Family Cancer History

YOUR PARENTS AND GRANDPARENTS								
	FIRST NAME	**CURRENT AGE**	**AGE AT DEATH**	**EVER HAD CANCER OR TUMOR?**			**TYPE OF CANCER or TUMOR**	**AGE AT DIAGNOSIS**
Your Mother				□ Yes	□ No	□ Unsure		
Your Mother's Mother				□ Yes	□ No	□ Unsure		
Your Mother's Father				□ Yes	□ No	□ Unsure		
Your Father				□ Yes	□ No	□ Unsure		
Your Father's Mother				□ Yes	□ No	□ Unsure		
Your Father's Father				□ Yes	□ No	□ Unsure		

YOUR SIBLINGS If you have different parents, please indicate whether you share the same mom or dad								
Sex at birth (check one)	**FIRST NAME**	**CURRENT AGE**	**AGE AT DEATH**	**EVER HAD CANCER OR TUMOR?**			**TYPE OF CANCER of TUMOR**	**AGE AT DIAGNOSIS**
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		

YOUR CHILDREN Please indicate whether they share the same parents								
Sex at birth (check one)	**FIRST NAME**	**CURRENT AGE**	**AGE AT DEATH**	**EVER HAD CANCER OR TUMOR?**			**TYPE OF CANCER or TUMOR**	**AGE AT DIAGNOSIS**
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		

YOUR AUNTS AND UNCLES (MOTHER'S SIDE) Only include your mother's siblings and indicate whether they are half-siblings; great-aunts and uncles can be added later.								
Sex at birth (check one)	**FIRST NAME**	**CURRENT AGE**	**AGE AT DEATH**	**EVER HAD CANCER OR TUMOR?**			**TYPE OF CANCER or TUMOR**	**AGE AT DIAGNOSIS**
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		

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Family Cancer History (continued)

YOUR AUNTS AND UNCLES (FATHER'S SIDE) Only include your mother's siblings and indicate whether they are half-siblings; great-aunts and uncles can be added later.								
Sex at birth (check one)	FIRST NAME	CURRENT AGE	AGE AT DEATH	EVER HAD CANCER OR TUMOR?			TYPE OF CANCER or TUMOR	AGE AT DIAGNOSIS
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		
□ Male □ Female				□ Yes	□ No	□ Unsure		

ADDITIONAL RELATIVES WITH CANCER This may include nieces/nephews, cousins, great-aunts/uncles, etc…						
Sex at birth (check one)	FIRST NAME	RELATIONSHIP	CURRENT AGE	AGE AT DEATH	TYPE OF CANCER OR TUMOR	AGE AT DIAGNOSIS
□ Male □ Female						
□ Male □ Female						
□ Male □ Female						
□ Male □ Female						
□ Male □ Female						
□ Male □ Female						

Do you have any specific questions or concerns you would like to discuss during your visit?