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Contact Information

Please fill out this form as completely as possible. You will not need to complete any additional medical health history forms on the day of your visit.

Name: _____ Date: _____

Permanent Address: _____

_____

Mailing Address (if different than above): _____

_____

☐ Home Phone: _____ ☐ Work Phone: _____

☐ Cell Phone: _____ ☐ Email: _____

Please check preferred method(s) of contact.

Date of Birth: _____ Age: _____

Referring Medical Provider: _____

Type/Name of Health Insurance: _____

Other contact (e.g. friend or relative) Name: _____

Relationship: _____ Phone: _____

Providers

☐ Primary Care Name: _____

Address: _____ Phone: _____

☐ Surgeon Name (if applicable): _____

Address: _____ Phone: _____

☐ Medical Oncologist Name (if applicable): _____

Address: _____ Phone: _____

☐ Other Provider Name (optional): _____

Address: _____ Phone: _____

Please check the box next to the physician's name if you would like us to send them a copy of your genetic risk assessment/evaluation. If your doctor(s) are outside the UCLA Health system, correct spelling, address and phone numbers are necessary for our office to send them records.

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Genetic Risk Assessment Questionnaire

To assess the risk for hereditary cancer in your family, we need to review your medical and family history. The focus will be on the history of cancer. The first part of the questionnaire is about your personal and 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 at this time or at any later time.
- Please take time before your appointment to gather as much of your family history information as possible
- Please be as descriptive as possible
- 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 make a copy for your records

Name: _____

Signature: _____

Date: _____

Patient Checklist

Please remember to bring the following to your appointment:

- Health Insurance Card
- Pathology reports (and other relevant medical records)
- Contact Information Form
- Personal history questionnaire
- Family history questionnaire

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Genetic Risk Assessment – Personal History

Name: _____ Date of Birth: _____

Occupation: _____ Marital Status: _____

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 (Eastern/Central European) Jewish
☐	☐	☐	Middle Eastern
☐	☐	☐	Other: _____

Countries of Origin

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

What is your height? _____ What is your current weight? _____

How is your health in general? _____

_____

Do you have any serious or chronic illnesses other than cancer? ☐ Yes ☐ No

_____

_____

_____

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Have you ever been diagnosed with cancer? ☐ Yes ☐ No

Type/site of cancer: _____

Date of diagnosis: _____ Age at diagnosis: _____

Type/site of cancer: _____

Date of diagnosis: _____ Age at diagnosis: _____

Type/site of cancer: _____

Date of diagnosis: _____ Age at diagnosis: _____

Check all that apply.

☐ Surgery Type: _____

☐ Chemotherapy

☐ Radiation therapy

☐ Blood transfusions Year: _____

☐ Relapse/Recurrence Year: _____

☐ Tamoxifen/Herceptin/Aromatase Inhibitors

☐ Other cancer therapy Specify: _____

***** If your treatment was not at UCLA, it is extremely important that you bring all pathology reports related to your cancer diagnosis. *****

Have you previously had any genetic testing? ☐ Yes ☐ No

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

If yes, please describe: _____

_____

***** If yes, we need copies of your relative's genetic test results for accurate risk assessment and testing. Please contact your relative(s) and ask for a copy of their genetic test results. *****

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WOMEN ONLY

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

How many times have you been pregnant? _____ ☐ None

How old were you when you had your first live birth? _____

How many biological children do you have? _____

Have you ever used IVF to become pregnant? _____

When was your last menstrual period? _____

Have you ever used oral contraceptives/birth control pills? ☐ Yes ☐ No

Age started: _____

For how long: _____

Do you still have menstrual periods? ☐ Yes ☐ No

Age periods stopped: _____

Which of the following describes why your periods stopped?

☐ Natural menopause ☐ Chemotherapy

☐ Uterus removed (hysterectomy) ☐ Ovaries removed (oophorectomy)

☐ Both uterus and ovaries removed

Have you taken hormone replacement therapy? ☐ Yes ☐ No

Starting year: _____ Ending year: _____ Type: _____

How many breast biopsies have you had? _____ ☐ None

How many were normal? _____

How many were atypical hyperplasia (ADH)? _____

How many were lobular carcinoma in situ (LCIS)? _____

Have you had a mastectomy? ☐ Yes ☐ No

Age: _____ Reason: _____

Have you had a hysterectomy? ☐ Yes ☐ No

Age: s _____ Reason: _____

Have you had an oophorectomy? ☐ Yes, One ☐ Yes, Both ☐ No

Age: _____ Reason: _____

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WOMEN AND MEN

Have you had a thyroidectomy? ☐ Yes ☐ No

Age: _____ Reason: _____

Please list any other surgeries and age at surgery

_____

_____

Do you have any of the following?

☐ Unusual skin findings (lumps, bumps, café au lait spots, light or dark spots)

Please describe: _____

☐ Colon Polyps Number: _____ Type (if known): _____

☐ Ulcerative colitis or Crohn's disease? Age at diagnosis: _____

☐ Personal and/or family history of any genetic disorders or inherited conditions

Please describe: _____

Exposures

Have you had any chemical or carcinogen exposures? ☐ Yes ☐ No

If yes, please specify: _____

Have you had any exposure to radiation? ☐ Yes ☐ No

If yes, please specify: _____

Do you <u>currently</u> smoke or use tobacco products? ☐ Yes ☐ No

Did you <u>previously</u> smoke or use tobacco products? ☐ Yes ☐ No

If yes, for how many years: _____ How many packs per day: _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If yes, how many drinks per week, on average: _____

On a scale of 1-5 (1=no concern and 5= extremely concerned) how would you rate your concern about developing cancer (or a second cancer)? _____

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SCREENING HISTORY

Women

Breast Screening

Do you do breast self-exam?
☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely/Never
Age at first: _____ Most recent (mo/yr): _____

Have you had a clinical breast exam?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a mammogram?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a breast MRI?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Gynecologic Screening

Have you had a PAP smear?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a pelvic exam?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a CA-125 blood test?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a transvaginal ultrasound?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

If you do any other breast or gynecologic screening, please specify:

_____

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SCREENING HISTORY

Men

Have you had a digital rectal exam?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a PSA blood test?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Do you do testicular self-exam?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Men and Women

Have you had a colonoscopy?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a sigmoidoscopy?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had an endoscopy?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a lower GI exam/barium enema?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

Have you had a full body skin exam?
☐ Never ☐ Every 6 months ☐ Yearly ☐ Every 2-3 years ☐ Less often
Age at first: _____ Most recent (mo/yr): _____

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FAMILY CANCER HISTORY QUESTIONNAIRE

- Please complete this form with information about your biological (or blood) relatives.
- The names of your family members are used only for discussion purposes.
- We ask that you fill this out to the best of your ability. If you are unsure of the information, please contact your relatives. This information will be reviewed at your appointment.

YOUR PARENTS AND GRANDPARENTS						
	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis
Mother						
Father						
Mother's Mother						
Mother's Father						
Father's Mother						
Father's Father						
YOUR BROTHERS AND SISTERS (If any have different parents, please note which are half-sibs and whether your share the same mother or father)						
Brother or Sister?	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis
YOUR CHILDREN						
Son or Daughter?	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis

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YOUR AUNTS AND UNCLES (MOTHER'S SIDE)						
Aunt or Uncle?	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis
YOUR COUSINS (MOTHER'S SIDE)						
Child of which aunt/uncle above	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis

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YOUR AUNTS AND UNCLES (FATHER'S SIDE)						
Aunt or Uncle?	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis

YOUR COUSINS (FATHER'S SIDE)						
Child of which aunt/uncle above	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis

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ADDITIONAL RELATIVES **WITH CANCER** NOT PREVIOUSLY LISTED (Nieces/nephews, great-grandparents, more distant cousins, etc.)						
Relative	First name	Current Age	Age at Death	Cancer? (Y/N/unsure)	Type of cancer	Age at Diagnosis

Notes/Additional information you wish to provide: