NYOH New York Oncology Hematology

www.newyorkoncology.com

Hereditary Cancer Risk Assessment

Personal and Family History Questionnaire

Name: ______________________________ Date: ______________________

Date of Birth: ______________________ Patient No. ______________________

Address: ____

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Occupation: ______________________

Gender: ☐ Female ☐ Male Marital Status: ______________________

Oncology Provider: ____

Referring Healthcare Provider: ____

Primary Care Physician: ____

Race: ____

Your Mother's family country/countries of origin (Prior to USA): ______________________

Your Father's family country/countries of origin (Prior to USA): ______________________

Do you have Central/Eastern European Jewish Ancestry or Ashkenazi Jewish Ancestry on either side of your family?
(Please check selection box)

Mother: ☐ YES ☐ NO ☐ UNSURE

Father: ☐ YES ☐ NO ☐ UNSURE

Please list any genetic testing you or your family members have had, and please obtain a copy of the genetic report prior to your visit:

____

____

____

Your appointment has been scheduled for:

Date: ______________________

Time: ______________________

Office: ______________________

Appointment with: ______________________

Please complete all sheets attached together in this questionnaire packet and bring it with you to your next appointment.

DO NOT DETACH ANY SHEETS

PATIENT INSTRUCTIONS: Please make sure you complete all 8 pages • Do NOT detach any pages from the stub

RE-ORDER FROM COOLEY GROUP • ALBANY • 518-690-7110

NY H New York Oncology Hematology

Patient Name: ______________________________

Patient No. ____________________

Hereditary Cancer Risk Assessment

Your Personal Health History

1. Your weight: ____________(pounds) Your height: ______________
2. Have you ever had cancer? ☐ YES ☐ NO *If YES, please continue below. If NO, skip to question 3.*

   Age at initial diagnosis________ Stage of cancer at diagnosis, if known: ______________________

   What type of cancer were you diagnosed with:

   ____

   What treatments did you receive for this cancer? (surgery, radiation, chemotherapy, hormone): ____________

   ____

   Have you had any other cancers? ☐ YES ☐ NO

   Please describe: ____

   ____
3. Please list any other genetic conditions, benign or precancerous growths you have had: ______________

   ____
4. Cancer Screening History:

Screening Test	***Date of Most Recent Exam***	***Results of Most Recent Exam***	***Age at First Exam***	***How often do you have this exam?***	***Comments***
Women:					
Self Breast Exams					
Clinical Breast Exams					
Mammograms					
Breast MRI					
PAP Smear					
CA-125					
Transvaginal Ultrasound					
Men:					
Digital Rectal Exam					
PSA Blood Test					
Men and Women:					
Skin Exams					
Colonoscopy					
Sigmoidoscopy					
Upper Endoscopy (EGD)					
Capsule Endoscopy					
ERCP (endoscopic retrograde cholangiopancreatography)					
Barium Enema					
Fecal Occult Stool Test					
Other/Notes:					

NYOH New York Oncology Hematology

Patient Name: ____________________

Patient No. ____________

Hereditary Cancer Risk Assessment

5. Have you been diagnosed with Colon Polyps? ☐ YES ☐ NO
   Age at first Colon Polyp ____________ Total Number of Colon Polyps ____________
   Type of Polyp (If known) ____________

6. Have you ever smoked? ☐ YES ☐ NO If Yes, How many packs per day ?______for how long? ______
   If you have quit, when did you quit? ____________
   Do you drink alcohol ☐ YES ☐ NO If Yes, How many drinks per week? ____________

7. **For Women:**

- At what age did your periods start?____________At what age did your periods stop? ____________
- Why did your periods stop? (Check one) ☐ Surgical/Cancer Treatment ☐ Natural Menopause ☐ Other: ______
  ____
- # of pregnancies ________ # of births ________ # of miscarriages or abortions ________
- At what age did you have your first child? ______ Did you breast feed for longer than 1 month? ☐ YES ☐ NO
- Complications with pregnancy?____________ C-sections? ____________
- History of abnormal pap smears? ☐ YES ☐ NO If Yes, Age: ______
- Have you ever taken hormone replacement therapy (HRT)? ☐ YES ☐ NO If yes:
  Type____________________ (estrogen or estrogen and progesterone?)
  Year you began HRT? ____________ Year you stopped HRT? ____________
- Have you ever taken oral contraceptives? ☐ YES ☐ NO Total # of years taken ____________
  What age did your start taking oral contraceptives? ________ What age did you stop? ________
- Have you ever had a breast biopsy? ☐ YES ☐ NO # of biopsies____________
  Did your biopsy show any of the following: Check here if Unknown ☐

Atypical Hyperplasia	☐ YES ☐ NO	age? ______	Side	☐ L ☐ R
Lobular Carcinoma in Situ (LCIS)	☐ YES ☐ NO	age? ______	Side	☐ L ☐ R
Ductal Carcinoma in Situ (DCIS)	☐ YES ☐ NO	age? ______	Side	☐ L ☐ R
Invasive Cancer	☐ YES ☐ NO	age? ______	Side	☐ L ☐ R

- Have you had a hysterectomy (surgical removal of uterus)? ☐ YES ☐ NO
  Why did you have a hysterectomy?____________________ How old were you? ______
- Have you had an oophorectomy (surgical removal of ovaries)? ☐ YES ☐ NO
  Did they remove: ☐ Both ovaries removed ☐ Right ovary only removed ☐ Left ovary only removed
  Why did you have a oophorectomy? ____________________ How old were you? ______

Patient Name: ____________________

Patient No. ____________________

Hereditary Cancer Risk Assessment

8. Please list any allergies: ____________________

9. Please list all your Healthcare Providers:

Healthcare Provider Name	Specialty

10. Please list other surgeries and year surgery completed:

Surgery	Year of Surgery

11. Please list any medical history: (such as diabetes, high blood pressure, depression, thyroid disorder)

Condition	Year diagnosed

NYOH New York Oncology Hematology

Patient Name: ______________________

Patient No. ______________

Hereditary Cancer Risk Assessment

YOUR FAMILY HEALTH HISTORY

PLEASE LIST ALL FAMILY MEMBERS EVEN THOSE WITHOUT CANCER

Your Children: (Please list all, even those without cancer)

Name	Sex	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

Your Brothers and Sisters: (Please list all, even those without cancer)

Name	Sex	Full or Half Sibling?	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				
	M / F	☐ Full Sib ☐ Maternal ½ Sib ☐ Paternal ½ Sib				

NYOH New York Oncology Hematology

Patient Name: ______________________________

Patient No. ____________________

Hereditary Cancer Risk Assessment

Your Nieces and Nephews: (Please list all, even those without cancer)

Name	Who is their parent? (ex: Sister Mary)	Sex	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				

Your Mother and Maternal Grandparents: (Please list all, even those without cancer)

Relative	Name	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
Mother					
Your Mother's Mother					
Your Mother's Father					

Aunts and Uncles on your MOTHER'S side of the family: (Please list all, even those without cancer)

Name	Sex	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

New York Oncology Hematology

Patient Name: ______________________

Patient No. ______________

Hereditary Cancer Risk Assessment

Cousins on your MOTHER'S Side of the Family (Please list all, even those without cancer)

Name	Who is their parent? (ex: Uncle Joe)	Sex	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				

Your Father and Paternal Grandparents: (Please list all, even those without cancer)

Relative	Name	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
Father					
Your Father's Mother					
Your Father's Father					

Aunts and Uncles on your FATHER'S side of the family: (Please list all, even those without cancer)

Name	Sex	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

NYOH New York Oncology Hematology

Patient Name: ______________________________

Patient No. ____________________

Hereditary Cancer Risk Assessment

Cousins on your FATHER'S Side of the Family (Please list all, even those without cancer)						
Name	Who is their parent? (ex: Uncle Joe)	Sex	Current Age	Age at Death	Type of Cancer	Age at Diagnosis
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				