Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

PATIENT IDENTIFICATION

Date (YYYY/MM/DD): ____________________________

Instructions:

1. Please list ALL blood relatives, whether or not they have had cancer. If you do not know the exact date of birth, please estimate the year. You may need to speak with other relatives to increase the accuracy of the information on this questionnaire. We understand that sometimes information is just not available. That is OK. Please send the package back with as much information as you can.
2. If you require more space, please use pages 11-12 to list your additional relatives and please indicate how these individuals are related to you.
3. If you have any questions about completing this questionnaire, please contact us at 416-480-5000 extension 85336.
4. You can mail the questionnaire back with the enclosed envelope or fax to 416-480-5859 Attn: Cancer Genetics and High Risk Program or scan and email with subject "Returning FHQ" to: occ.genetics@sunnybrook.ca
5. **Your completed questionnaire will be reviewed by a genetic counsellor. Due to the high volume of referrals, if your personal and/or family does not meet our referral criteria, we may decline to see you in our clinic.**

First Name:______________________________ **Last Name:**__________________________________ **Date of Birth (YYYY/MM/DD):**_________________

Phone Number(s) *Please check preferred number to contact you*: ☐ **Home**: _______________ ☐ **Work**:_________________ ☐ **Cellular**: _______________

Email address:____ Can we contact you for appointments/questions via email: ☐ Yes ☐ No

What is your ANCESTRY? i.e. English, Spanish, Hungarian, Turkish, Iraqi, Filipino, Japanese, Trinidadian, etc.

Mother's Mother: i.e. *Chinese*_________________________ **Jewish* ☐ *Yes* ☐ *No* *if **yes**,* ☐ *Ashkenazi* ☐ *Sephardic* ☐ *Other:*_______________________

Mother's Father:________________________________ **Jewish* ☐ *Yes* ☐ *No* *if **yes**,* ☐ *Ashkenazi* ☐ *Sephardic* ☐ *Other:*_______________________

Father's Mother:________________________________ **Jewish* ☐ *Yes* ☐ *No* *if **yes**,* ☐ *Ashkenazi* ☐ *Sephardic* ☐ *Other:*_______________________

Father's Father:________________________________ **Jewish* ☐ *Yes* ☐ *No* *if **yes**,* ☐ *Ashkenazi* ☐ *Sephardic* ☐ *Other:*_______________________

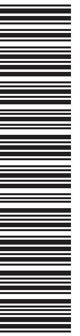
Your background (optional): ☐ Asian ☐ Black ☐ Hispanic ☐ Native American ☐ White ☐ Other:________________________________

Have you or your family members been seen for genetic counselling or testing?
☐ Yes ☐ No If **yes**, please list the name(s) of the person seen, the name of the clinic, and the reason for their visit.

Name: ____________________________________ Clinic:_______________________________ Reason: ____________________________________

* This information will help us assess your risk of predisposition to cancer as certain ethnic populations may have a higher frequency of inherited factors.

PR 47240 (2018/08/16)



INFORMATION REQUIRED FOR PRE-REGISTRATION
Please Print Clearly

Home Address: ______________________ City/Province: ______________ Postal Code: ______________

Ontario Health Care Number (OHIP): ______________ Version Code: ______________

Referring Doctor: ______________ Phone Number: ______________ Address: ______________

Family Doctor (if different): ______________ Phone Number: ______________ Address: ______________

Surgeon (if applicable): ______________ Phone Number: ______________ Address: ______________

Other Doctor (if applicable): ______________ Phone Number: ______________ Address: ______________

Emergency Contact:

Name: ______________________ Relationship: ______________ Phone Number #1: ______________

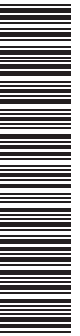
Phone Number #2: ______________

Next of Kin: ______________________

Name: ______________________ Relationship: ______________ Phone Number #1: ______________

Phone Number #2: ______________

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

Name: ______________________ HFN (if known): ______________

PERSONAL MEDICAL HISTORY - WOMEN ONLY

Age when menstrual periods started: ______________ Are you still menstruating? ☐ Yes ☐ No If **no**, age stopped? ______________

Age at first live birth: ______________ Needed for Risk Models: a) Your current height: ______________ b) Your current weight: ______________

Have you had your uterus &/or ovaries removed? ☐ Yes ☐ No If **yes,** ☐ Uterus ☐ Both Ovaries ☐ One Ovary ☐ Age removed: ______________

Reason: ______________________________

Have you ever used Hormone Replacement therapy (HRT)? ☐ Yes ☐ No If **yes,** total number of years? Age range?: ______________

Do you have breast implants? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No If **yes,** date of last mammogram: ______________

Have you ever had a breast MRI? ☐ Yes ☐ No If **yes,** date of last breast MRI: ______________

Have you ever had a breast biopsy? ☐ Yes ☐ No If **yes,** how many and what was the diagnosis? ______________

Have you smoked or used tobacco in the past 6 months? ☐ Yes ☐ No

Have you ever had a colonoscopy? ☐ Yes ☐ No If **yes,** how many? ________ Starting at what age? ______________

Name of gastroenterologist/surgeon? ______________

Have you ever had colon polyps found? ☐ Yes ☐ No If **yes,** how many? ________ Starting at what age? ______________

Types of polyps (if known)? ______________

PERSONAL MEDICAL HISTORY - MEN ONLY

Have you ever had a prostate biopsy ☐ Yes ☐ No If **yes**, when done? ______________

Have you ever had an elevated PSA? ☐ Yes ☐ No If **yes,** what was the value (if known)? ______________

Have you smoked or used tobacco in the past 6 months? ☐ Yes ☐ No

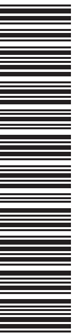
Have you ever had a colonoscopy? ☐ Yes ☐ No If **yes,** how many? ________ Starting at what age? ________

Name of gastroenterologist/surgeon? ______________

Have you ever had colon polyps found? ☐ Yes ☐ No If **yes,** how many? ________ Starting at what age? ________

Types of polyps (if known)? ______________

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

Name: ______________________ HFN (if known):__________

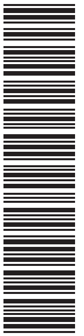
Please list **ALL family members**, including those who have not had cancer. If you require more space, please go to page 11/12.

	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
Example	Jane Smith	1931-Jun-23		☐ M ☑ F ☐______	Toronto, ON	☑ Yes ☐ No	*Colon*	49	75	stroke
	Jack Smith		Early 70s	☑ M ☐ F ☐______	Italy	☐ Yes ☑ No			N/A	N/A
	Jenny Smith	1933-Aug-25		☐ M ☑ F ☐______	Hamilton, ON	☑ Yes ☐ No	*Breast* *Breast*	55 61	Late 60s	Heart attack

	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
You				☐ M ☐ F ☐______		☐ Yes ☐ No				
Your children				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
Your brothers & sisters				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
Your partner				☐ M ☐ F ☐______		☐ Yes ☐ No				

Do any of your brothers or sisters have a different parent? ☐ Yes ☐ No
If **yes**, please indicate in the margin whether you share the same mother or father

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

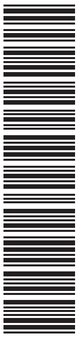
Name: ______________________ HFN (if known): ______________

Your Nephews and Nieces

Please indicate how each nephew/niece is related to you, i.e. which one of your brother(s) or sister(s) is the parent.
If you require more space, please go to page 11/12.

Name of your brother or sister who is the parent	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

Name: ______________________________ HFN (if known):______________

Your Mother's Family History

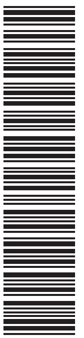
If you require more space, please go to page 11/12.

	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
Your mother				☐ M ☐ F ☐______		☐ Yes ☐ No				
Your mother's mother				☐ M ☐ F ☐______		☐ Yes ☐ No				
Your mother's father				☐ M ☐ F ☐______		☐ Yes ☐ No				
Your mother's brothers/ sisters				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				

Do any of your mother's brothers or sisters have a different parent? ☐ Yes ☐ No

If **yes**, please indicate in the margin whether they share the same mother or father

PR 47240 (2018/08/16)

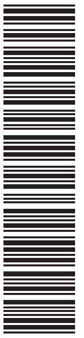


Your Maternal First Cousins

Please indicate how each cousin is related to you, i.e. which one of your mother's brother(s) or sister(s) is the parent.
If you require more space, please go to page 11/12.

Name of your mother's brother or sister whois the parent	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

Name: ______________________ HFN (if known): ____________

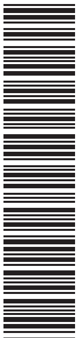
Your Father's Family History

If you require more space, please go to page 11/12.

	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
Your father				☐ M ☐ F ☐_______		☐ Yes ☐ No				
Your father's mother				☐ M ☐ F ☐_______		☐ Yes ☐ No				
Your father's father				☐ M ☐ F ☐_______		☐ Yes ☐ No				
Your father's brothers/ sisters				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				

Do any of your father's brothers or sisters have a different parent? ☐ Yes ☐ No
If **yes**, please indicate in the margin whether they share the same mother or father

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

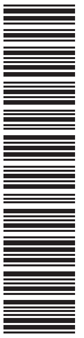
Name: ______________________ HFN (if known):______________

Your Paternal First Cousins

Please indicate how each cousin is related to you, i.e. which one of your father's brother(s) or sister(s) is the parent.
If you require more space, please go to page 11/12.

Name of your father's brother or sister who is the parent	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				
				☐ M ☐ F ☐_______		☐ Yes ☐ No				

PR 47240 (2018/08/16)



Sunnybrook
HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

Name: ______________________________ HFN (if known):______________

Additional Relatives Diagnosed With Cancer

Please indicate how each of these individuals is related to you. (example: mother's paternal first cousin)
If you require more space, please go to page 11/12.

Relationship to you	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				

FAMILY MEDICAL HISTORY

Have any family members had colon polyps? ☐ Yes ☐ No If **yes**, name:______________________ how many polyps?____________

name:______________________ how many polyps?____________

name:______________________ how many polyps?____________

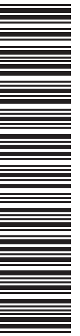
Have any of your female relatives had their uterus and/or ovaries removed? ☐ Yes ☐ No

If **yes**, name:______________ reason:________________________ age removed:_____ ☐ Uterus ☐ Both Ovaries ☐ One Ovary

name:______________ reason:________________________ age removed:_____ ☐ Uterus ☐ Both Ovaries ☐ One Ovary

name:______________ reason:________________________ age removed:_____ ☐ Uterus ☐ Both Ovaries ☐ One Ovary

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

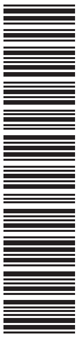
Name: ____________________ HFN (if known): ____________

ADDITIONAL SPACE

Please use pages 11 and 12 for relatives you were not able to fit on previous sections.

Relationship to you	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				
				☐ M ☐ F ☐ ______		☐ Yes ☐ No				

PR 47240 (2018/08/16)



Sunnybrook HEALTH SCIENCES CENTRE

Personal and Family History Questionnaire (FHQ)

Name: ______________________________ HFN (if known): ________________

ADDITIONAL SPACE

Please use page 12 for relatives you were not able to fit on previous sections.

Relationship to you	First and Last name	Date of birth (DOB) (y-m-d)	If DOB unknown, approx. age?	Sex	Place where they live or lived if deceased	Did they have cancer?	If yes, what type of cancer?	Age at diagnosis of cancer	Age at death	Cause of death
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				
				☐ M ☐ F ☐______		☐ Yes ☐ No				

PR 47240 (2018/08/16)