Sunnybrook
ODETTE CANCER CENTRE
A Cancer Care Ontario Partner

PERSONAL AND FAMILY HISTORY QUESTIONNAIRE

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 the back of the page(s) or extra page(s) to list your additional relatives**. Try to follow the same pattern and order of information as much as possible. For the last page, 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 416-480-6002 **Attn: Cancer Genetics and High Risk Program** or scan and email with subject "**Returning FHQ**" to: josephine.lorefice@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.**

Name:_____ **Date of Birth:**_____ **OHIP Number:**_____

Address:_____ **City:**_____ **Province:**_____ **Postal Code:**_____

Telephone Number(s): □ **Home**:_____ □ **Work**:_____ □ **Cellular**:_____
Please check preferred number to contact you

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:_____ **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(s):_____ 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.

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)?_____

Please list **ALL family members**, including those who have not had cancer.
If you require more space, please use the back of the form.

	Last name, first 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
EXAMPLES	***Smith, Jane***	***1931-Jun-23***		☐ **M** ☒ **F**	***Toronto, ON***	☒ **Yes** ☐ **No**	***Colon***	***49***	***75***	***stroke***
	Smith, Jack		***Early 70s***	☒ **M** ☐ **F**	***Italy***	☐ **Yes** ☒ **No**			***N/A***	***N/A***
	Smith, Jenny	***1933-Aug-25***		☐ **M** ☒ **F**	***Hamilton, ON***	☒**Yes** ☐ **No**	***Breast*** ***Breast***	***55*** ***61***	***Late 60s***	***Heart attack***

You				☐ M ☐ F		☐ Yes ☐ No				
Your children **1**				☐ M ☐ F		☐ Yes ☐ No				
2				☐ M ☐ F		☐ Yes ☐ No				
3				☐ M ☐ F		☐ Yes ☐ No				
Your brothers & sisters **1**				☐ M ☐ F		☐ Yes ☐ No				
2				☐ M ☐ F		☐ Yes ☐ No				
3				☐ M ☐ F		☐ Yes ☐ No				
4				☐ 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

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 additional space, please use back of this form.

Name of your brother or sister who is the parent	Last name, first name of your niece/nephew	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				

Your Mother's Family History

	Last name, first 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				

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 additional space, please use back of this form.

Name of your mother's brother or sister who is the parent	Last name, first name of your cousin	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				

Your Father's Family History

	Last name, first 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				

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 additional space, please use back of this form.

Name of your father's brother or sister who is the parent	Last name, first name of your cousin	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				

Additional Relatives

Please indicate how each of these individuals is related to you. (example: mother's paternal first cousin)
If you require additional space, please use back of this form.

Relationship to you	Last name, first 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				

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
name:_____ reason:_____ age removed:_____ □ Uterus □ Both Ovaries □ One Ovary