Stanford HEALTH CARE
STANFORD MEDICINE

Personal and Family History Questionnaire

It is very important for you to complete this form to the best of your ability and **return it well in advance of your scheduled appointment**. This allows us appropriate time to prepare, so the consultation is as beneficial as possible. You may also receive a brief phone call to clarify or gather additional info.
Please consult with other family members, if necessary, to increase the accuracy of this information.

INFORMATION ABOUT YOU

Name: ____ **Date of Birth**: ________________
First Middle Last (Prior Names)

Insurance Type (e.g. BC/BS, Cigna, Medicare, Medical): _____________ **Plan Type:** ___ HMO ___ PPO ___ EPO

Marital Status: _______________ **Occupation:** ________________ **Referring Provider:** ____________________________

What countries are your paternal ancestors from (before the US)? (e.g., Ireland, Korea, Lebanon, Chile, etc.): _________________

What countries are your maternal ancestors from (before the US)? (e.g., Estonia, Japan, Togo, Venezuela, etc.): _________________

Is your family of Central/Eastern European (Ashkenazi) Jewish ancestry? ___ Yes ___ No

Are your mother and father related by blood (eg. cousins)? ___ Yes ___ No

Females Only:

Age at menarche (first period): ___________________ Amount of time on birth control pills: _____N/A ____
How many times have you been pregnant: ___________N/A____ Age at birth of first child: ________ N/A ____
Amount of time breast feeding: _______N/A ____ Amount of time on hormone replacement therapy: ______N/A ____
Age at menopause: _________________N/A____ Do you do monthly self-breast exams? ____Y____N____Sometimes
Age at first mammogram: __________ ____ N/A____ Do you get annual mammograms? ____Y____N____Sometimes
Have you ever had a breast MRI? ___ Y___ N If yes, frequency? ______________
How many breast biopsies have you had? _______

How many were normal? Number: ______ Don't know___
How many were "atypical ductal hyperplasia (ADH)"? Number: _______ Don't know___
How many were "lobular carcinoma in situ (LCIS)" or "lobular neoplasia"? Number: _______ Don't know___

Have you had a mastectomy (surgical removal of one or both breasts)? ___ No ___ One (left or right?) ___ Both
Have you had a hysterectomy (surgical removal of uterus)? ___Yes ___ No
Have you had an oophorectomy (surgical removal of one or both ovaries)? ___ No ___ One (left or right?) ___ Both
Have you ever taken Tamoxifen (to treat or prevent breast cancer)? ___Yes ___No
Amount of time Tamoxifen taken?: ______

Females & Males:

Smoking history?: ___ Never ___ Previous Smoker: # years? ____
Average amount smoked per day? ____Quit in what year? ____
Current Smoker: # years? _______ How much do you smoke per day? _________
Average number of alcoholic drinks per week?: ____________________

How many colonoscopies have you had?: _____ In what year(s)? ______________________________
Cumulative number of polyps identified on colonoscopy?: ____________________________________
Pathology of polyps if known (e.g. adenomas, hyperplastic, hamartomatous)? ________________________

Have you ever had an upper endoscopy (EGD)?: ___ Yes ___ No If yes, what were the findings? ______________________
In your routine life, how many days per week do you exercise? ______ If yes, what form of exercise? ___________________
Have you ever had a medical condition treated with radiation? ___ Yes ___ No If yes, explain? ________________________
Your Cancer History:
Type(s) of Cancer: ____________________________________ Age(s) at Diagnosis: ______________________________
Other History (i.e. uterine fibroids, other benign tumors, thyroid disease, etc.):______________________

GENETIC TESTING HISTORY FOR YOU

Have you ever pursued cancer genetic testing in the past? ___ Yes ___ No

If Yes, in what year? ________________

If Yes, which genes were tested? ____

____

If Yes, which lab performed the testing? (examples: Myriad, Ambry, Invitae, GeneDx, Counsyl, Color, LabCorp, Quest)

____

IF YES, PLEASE INCLUDE A COPY OF YOUR GENETIC TEST RESULT WITH THIS COMPLETED QUESTIONNAIRE.

GENETIC TESTING HISTORY FOR YOUR FAMILY MEMBERS

Have any of your family members ever pursued cancer genetic testing in the past? ___ Yes ___ No

If Yes, which family member(s), and please denote whether the relative is maternal or paternal?

____

If Yes, in what year(s)? ____

If Yes, which genes were tested? ____

____

____

If Yes, which lab performed the testing? (examples: Myriad, Ambry, Invitae, GeneDx, Counsyl, Color, LabCorp, Quest)

____

IF YES, PLEASE INCLUDE A COPY OF YOUR FAMILY MEMBER'S GENETIC TEST RESULT WITH THIS COMPLETED QUESTIONNAIRE.

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FAMILY HISTORY

YOUR PARENTS				
	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Mother	☐deceased			
Father	☐deceased			

YOUR CHILDREN (WITH OR WITHOUT CANCER)					
	Male/Female?	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Child 1	☐M ☐F	☐deceased			
Child 2	☐M ☐F	☐deceased			
Child 3	☐M ☐F	☐deceased			
Child 4	☐M ☐F	☐deceased			
Child 5	☐M ☐F	☐deceased			
Child 6	☐M ☐F	☐deceased			
Child 7	☐M ☐F	☐deceased			
Child 8	☐M ☐F	☐deceased			

YOUR BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)					
If half-sibling, please denote maternal-half or paternal-half	Male/Female?	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Sibling 1	☐M ☐F	☐deceased			
Sibling 2	☐M ☐F	☐deceased			
Sibling 3	☐M ☐F	☐deceased			
Sibling 4	☐M ☐F	☐deceased			
Sibling 5	☐M ☐F	☐deceased			
Sibling 6	☐M ☐F	☐deceased			
Sibling 7	☐M ☐F	☐deceased			
Sibling 8	☐M ☐F	☐deceased			

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YOUR NIECES AND NEPHEWS (WITH OR WITHOUT CANCER)					
	Male/Female?	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Niece / Nephew 1 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 2 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 3 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 4 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 5 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 6 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 7 Child to sibling # _____	☐M ☐F	☐deceased			
Niece / Nephew 8 Child to sibling # _____	☐M ☐F	☐deceased			

YOUR GRANDPARENTS				
	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Maternal Grandmother	☐deceased			
Maternal Grandfather	☐deceased			
Paternal Grandmother	☐deceased			
Paternal Grandfather	☐deceased			

YOUR MOTHER'S BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)					
Please denote if maternal or paternal half-sibling to your mother	Male/Female?	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Aunt / Uncle 1	☐M ☐F	☐deceased			
Aunt / Uncle 2	☐M ☐F	☐deceased			
Aunt / Uncle 3	☐M ☐F	☐deceased			
Aunt / Uncle 4	☐M ☐F	☐deceased			
Aunt / Uncle 5	☐M ☐F	☐deceased			
Aunt / Uncle 6	☐M ☐F	☐deceased			
Aunt / Uncle 7	☐M ☐F	☐deceased			
Aunt / Uncle 8	☐M ☐F	☐deceased			

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YOUR FATHER'S BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)					
Please denote if maternal or paternal half-sibling to your father	Male/Female?	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
Aunt / Uncle 1	□M □F	□deceased			
Aunt / Uncle 2	□M □F	□deceased			
Aunt / Uncle 3	□M □F	□deceased			
Aunt / Uncle 4	□M □F	□deceased			
Aunt / Uncle 5	□M □F	□deceased			
Aunt / Uncle 6	□M □F	□deceased			
Aunt / Uncle 7	□M □F	□deceased			
Aunt / Uncle 8	□M □F	□deceased			

ANY OTHER EXTENDED BLOOD RELATIVES (ONLY LIST IF THEY HAVE A HISTORY OF CANCER) List anyone else with cancer such as your 1st & 2nd cousins and grandparents' siblings					
Denote Relationship (i.e. first cousin, etc.) and circle M for maternal or P for paternal; For first cousins please also denote which # aunt or uncle is their parent	Male/Female?	Current **Age** -OR- **Age** at Death	Type(s) of Cancer (i.e. where cancer started)	Age at Diagnosis	Other History (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease, etc.)
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			
M / P	□M □F	□deceased			

Please return the completed questionnaire to us *PRIOR* to your scheduled appointment. Thank you! If you have any questions please do not hesitate to call us (650) 497-1290

Email to DL-SMCCS@stanfordhealthcare.org **-OR-** Fax: (650) 498-5150