FAMILY HISTORY QUESTIONNAIRE

Completing this questionnaire will help us to determine the risk of a hereditary cancer predisposition in your family. Please answer these questions as completely as possible. If you are uncertain about any information, please write in your best guess or write unknown.

Names of family members are used only as a reference. This information will not be used to contact your relatives.

If yourself or any family member is transgender or non-binary, please make a note on the last page so that we can assess organs at risk for cancer.

If you have questions, please contact our office at 714-288-3500. Fax the completed questionnaire to 714-288-3510, you may also drop off or mail your questionnaire to the Genetics Center at least 2 days prior to your appointment.

PERSONAL HISTORY

Name: _____ _____ _____
First Last Maiden (If applicable)

Date of birth: _____ Sex at birth: ☐Male ☐Female ☐Other
(MM/DD/YYYY)

Have you ever been diagnosed with cancer? ☐Yes (Y) ☐No (N) ☐Unknown (U)

If yes, what type(s) and at what age(s) were you diagnosed? (below)

Age at Diagnosis	Cancer Location	Pathology (Cancer Type)	Treatment
Example: 45	*Breast*	*Lobular Carcinoma*	*Chemotherapy, lumpectomy*

SCREENING HISTORY

WOMEN ONLY

Age at first period _____ Age at first live birth _____ (if applicable)

Have you ever used oral contraceptives? ☐Y ☐N ☐U If yes, how many years? _____
Between what ages? _____

Have you gone through menopause yet? ☐Y ☐N ☐U If yes, at what age? _____

Have you taken hormone replacement therapy? ☐Y ☐N ☐U If yes, how many years? _____

Have you had any breast biopsies? ☐Y ☐N ☐U If yes, how many? _____
If yes, at what age(s)? _____
Was atypical hyperplasia seen? ☐Y ☐N ☐U
If atypical hyperplasia? ☐DCIS or ☐LCIS

Have you had a hysterectomy (removal of uterus)? ☐Y ☐N ☐U If yes, at what age? _____
Reason: _____

Have you had an oophorectomy (removal of ovaries)? ☐Y ☐N ☐U If yes, at what age? _____
If yes, ☐Right ☐Left ☐Bilateral
Reason: _____

MEN AND WOMEN

Have you had a colectomy (removal of colon)?	☐Y ☐N ☐U	If yes, at what age? _____ If yes, ☐ Partial ☐ Complete ☐ Unknown Reason: _____
Have you ever had colon polyps?	☐Y ☐N ☐U	If yes, how many? _____ If yes, what type? _____
Have you been diagnosed with ulcerative colitis?	☐Y ☐N ☐U	If yes, at what age? _____
Have you had a mastectomy (removal of breast tissue)?	☐Y ☐N ☐U	If yes, at what age(s)? _____ If yes, ☐ Right ☐ Left ☐ Bilateral Reason: _____
Have you been diagnosed with fibrocystic breast disease?	☐Y ☐N ☐U	
Have you had a thyroidectomy (removal of thyroid)?	☐Y ☐N ☐U	If yes, at what age? _____ Reason: _____
Have you had any other surgeries?	☐Y ☐N ☐U	If yes, what? _____
Have you had unusual skin findings (lumps, bump, lesions, light or dark spots)?	☐Y ☐N ☐U	If yes, what? _____
Have you or a family member ever been diagnosed with a genetic disorder?	☐Y ☐N ☐U	If yes, what? _____ Who? _____

FAMILY HISTORY

Family Countries of Origin before the United States (example: England, Nigeria, Mexico, Taiwan)
Maternal (Mother's) side: _____ Paternal (Father's) side: _____

Are either of your parents of Ashkenazi (Eastern/Central European) Jewish descent? ☐Y ☐N ☐U
If yes, ☐ mother's side, ☐ father's side, ☐ both

Has anyone in your family had testing for a hereditary (inherited) cancer syndrome? ☐Y ☐N ☐U
If yes, what gene testing? _____ Who was tested? _____
What were the results? _____
****If yes, bringing a family member's test results with you to the appointment may help in determining your risks.****

When completing the section below (next page):

- Please include ALL BLOOD RELATIVES whether or not they have had cancer.
- If there is not enough space for all relatives to be listed, please list answers on a separate sheet of paper.
- Please consult other family members, if necessary, to increase the accuracy of this information.
- If exact ages are not known, please provide your best estimate.

YOUR PARENTS AND GRANDPARENTS

Name	**Alive (A)/ Deceased (D)**	**Current Age/Age at Death**	**Affected with cancer?**	**Age at cancer diagnosis**	**Location of Cancer** (breast, lung, etc.)	**Pathology** (if known) (adenomatous, papillary, etc.)
Example: Relative	☐*A* ☐ *D*	*40*	☐*Y* ☐ *N*	*35*	*Colon*	*Adenomatous*
Your Mother	☐A ☐D		☐Y ☐N			
Your Father	☐A ☐D		☐Y ☐N			
Your mother's mother	☐A ☐D		☐Y ☐N			
Your mother's father	☐A ☐D		☐Y ☐N			
Your father's mother	☐A ☐D		☐Y ☐N			
Your father's father	☐A ☐D		☐Y ☐N			

YOUR BROTHERS AND SISTERS

Sibling	**Sex at birth**	**Alive/ Deceased**	**Current Age/Age at Death**	**Affected with cancer?**	**Age at cancer diagnosis**	**Location of Cancer** (breast, lung, etc.)	**Pathology**
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			

YOUR CHILDREN

Child	Sex at birth	Alive/ Deceased	Current Age/Age at Death	Affected with cancer?	Age at cancer diagnosis	Location of Cancer (breast, lung, etc.)	Pathology
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			

YOUR AUNTS AND UNCLES (ON YOUR MOTHER'S SIDE)

Mother's Sibling	Sex at birth	Alive/ Deceased	Current Age/Age at Death	Affected with cancer?	Age at cancer diagnosis	Location of Cancer (breast, lung, etc.)	Pathology
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			

Your Aunts and Uncles (on your father's side)

Father's Sibling	**Sex at birth**	**Alive/ Deceased**	**Current Age/Age at Death**	**Affected with cancer?**	**Age at cancer diagnosis**	**Location of Cancer** (breast, lung, etc.)	**Pathology**
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			
Name	☐M ☐F	☐A ☐D		☐Y ☐N			

Nieces and Nephews (children of your brothers and sisters)

Niece / Nephew	**Sex at birth**	**Alive/ Deceased**	**Current Age/Age at Death**	**Affected with cancer?**	**Age at cancer diagnosis**	**Location of Cancer** (breast, lung, etc.)	**Pathology**
Name: Parent's Name:	☐M ☐F	☐A ☐D		☑Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			

COUSINS (CHILDREN OF YOUR MOTHER'S BROTHERS AND SISTERS)

Maternal Cousin	Sex at birth	Alive/ Deceased	Current Age/Age at Death	Affected with cancer?	Age at cancer diagnosis	Location of Cancer (breast, lung, etc.)	Pathology
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			

COUSINS (CHILDREN OF YOUR FATHER'S BROTHERS AND SISTERS)

Paternal Cousin	Sex at birth	Alive/ Deceased	Current Age/Age at Death	Affected with cancer?	Age at cancer diagnosis	Location of Cancer (breast, lung, etc.)	Pathology
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name:	☐M ☐F	☐A ☐D		☐Y ☐N			

Additional Relatives

Other Relative	Sex at birth	Alive/ Deceased	Current Age/Age at Death	Affected with cancer?	Age at cancer diagnosis	Location of Cancer (breast, lung, etc.)	Pathology
Name: Parent's Name: Relation to you:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name: Relation to you:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name: Relation to you:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name: Relation to you:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name: Relation to you:	☐M ☐F	☐A ☐D		☐Y ☐N			
Name: Parent's Name: Relation to you:	☐M ☐F	☐A ☐D		☐Y ☐N			

Additional Notes:

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Your signature below confirms that the information submitted above is true and correct to your knowledge, and that you are the patient or legal guardian.

Patient or Legal Guardian (Print):____

*Patient or Legal Guardian's Signature:____ Date: 10/10/2024
*(If submitting electronically: By printing your name on this line, it is considered your signature on this form)