Genetic Risk Evaluation and Testing Program
12123 SW 69th Ave
Tigard, OR 97223
Phone: 971-708-7600 Fax: 971-762-4632

Personal and Family History Questionnaire

Please fill out and return this form by mail in the addressed/stamped envelope (Medical records 265 N Broadway, Portland, OR 97227) no later than the Friday before your appointment date. Or fax to 971-762-4632.

If this form is not mailed a week before your appointment, please call 971-708-7600 to reschedule.

Date:_____

Name: _____ Date of Birth:_____

Referring Healthcare Provider:_____

Reason for referral: _____

Gender at birth: Female / Male Gender identity: Female/Male/transgender/_____

Are you adopted? YES NO Are you a twin? YES NO, if yes -are you identical or fraternal? Circle one

Ancestry: **Please select all that apply**

Mother's Side

☐ Western/Northern European ☐ Jewish
☐ Central/Eastern European ☐ African
☐ Middle Eastern ☐ Asian
☐ Latin American/Caribbean ☐ Native American

Father's Side

☐ Western/Northern European ☐ Jewish
☐ Central/Eastern European ☐ African
☐ Middle Eastern ☐ Asian
☐ Latin American/Caribbean ☐ Native American

Please list any *hereditary cancer genetic testing* you or your family members have had.
If a family member has previously been tested, please obtain a copy of their results. A copy of results will be needed in order for you to proceed with testing for any known mutation in the family. It is helpful to obtain all family members genetic reports even if negative:

_____

_____

Note: If you have death certificates or pathology reports on family members with cancer or pre-cancer, please include with packet

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Your Personal Health History

Cancer history:

- Do you have a current or past diagnosis of cancer? YES NO

  If the answer is yes, please answer these questions, if no then proceed to endoscopy history.

  What type of cancer?_____

  What age were you when you were diagnosed?_____

  What treatments did you receive for this cancer? (surgery, radiation, chemotherapy, hormonal)

  _____

  Have you ever had any other cancers, either current or past? YES NO

  Please list type and age(s) at diagnosis:

  _____

  _____

Endoscopy history:

- Have you ever had a colonoscopy? YES NO
- Age at first colonoscopy _____ Date of last colonoscopy_____

  Have you ever had Colon Polyps? YES NO

  Age at first colon Polyp _____ Total Number of colon Polyps _____

  Type of Polyp (If known) _____
- Have you ever had an upper endoscopy? YES NO

Habits/Social history

Have you ever smoked? YES NO. If Yes, How many packs per day_____

Age started_____ Age stopped_____

Do you drink alcohol? YES NO. If Yes, How many drinks per week? _____

Occupation:_____ Retired? YES/NO

Relationships: Single/Significant other/ Partnered/Married/_____ circle or fill in the blank

For Women:

Age periods started? _____Age at Menopause? _____ Circle one: Surgical/Cancer treatment/Natural

#of pregnancies_____ #of live births_____ Number of C-sections _____

At what age did you have your first child? _____ Did you breast feed for longer than 1 month? YES NO

History of abnormal pap smears? YES NO Age if yes _____

Have you ever taken hormones for menopause? YES NO Type _____ How long? _____

Have you ever taken oral contraceptives? YES NO Total # years taken _____

Date (Month/Year) of most recent mammogram _____

Have you ever had a breast biopsy? YES NO # of biopsies_____

Was your biopsy normal or abnormal? _____Check here if Unknown _____

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1. Please List surgeries and year surgery completed:

Surgery	Year of surgery

2. Please list any medical history

Condition	Year diagnosed

3. Please list any allergies to medications:

_____

4. Please list medications:

Medication	Dosage	Frequency

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This next section is about your PARENTS and GRANDPARENTS - please list all biological relatives including relatives without a history of cancer

Parents and Grandparents	First Name	Living? Circle one	Cancer YES NO circle one Type: list type if Yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Mother		YES NO	YES NO Type:		
Your Mother's Mother		YES NO	YES NO Type:		
Your Mother's Father		YES NO	YES NO Type:		
Father		YES NO	YES NO Type:		
Your Father's Mother		YES NO	YES NO Type:		
Your Father's Father		YES NO	YES NO Type:		

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This next section is about your CHILDREN- please list all biological children including those without a history of cancer

Please indicate if any of your children are twins. Please note if they are identical twins or fraternal twins. If your child is adopted, please specify if they are related to someone else in the family.

Your Biological Children	First Name	Living? Circle one	Cancer YES NO circle one Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And #daughters Your child has -Use 0 if none
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:

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This next section is about your SIBLINGS - please list all biological siblings including those without a history of cancer

Your Siblings: How many full sisters _____ How many full brothers______
How many half- sisters______ How many half -brothers _____
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, circle shared parent	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And # daughters each sibling has -Use 0 if none
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:

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This next section is about your MOTHER'S SIBLINGS - please list all biological aunts and uncles including those without a history of cancer

Your Mother's siblings:
How many full sisters ___________ and brothers ___________ does your mother have?
How many half- sisters_______ How many half -brothers ______
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, circle shared parent	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters each relative has. -Use 0 if none
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:

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List **your *first* Cousins** on your **MOTHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer**.

Circle gender and write first Name of each	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

Add any additional maternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known

Circle gender and write first Name of each	How are they related to you? (Ex: Mother's maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

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Your father's siblings:

How many full sisters ___________ and brothers ___________ does your father have?

How many half- sisters______ How many half -brothers _____

Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, circle shared parent	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters Each relative has. -Use 0 if none
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:
□ Full □ Half: If half sib, circle shared parent Mother/Father	Male/Female First name:	YES NO	YES NO Type:			Sons: Daughters:

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List **your *first* Cousins** on your **FATHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer**.

Circle gender and write first Name of each	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

Add any additional paternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known

Circle gender and write first Name of each	How are they related to you? (Ex: fathers, maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

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