

PLEASE REPORT TO SUITE E250, OUTPATIENT REGISTRATION THE DAY OF YOUR APPOINTMENT.

*Penn Medicine Virtua Cancer Program
Cancer Genetics Program
Center for Health and Wellness
200 Bowman Drive, Suite D290
Voorhees, NJ 08043
Phone: 856-247-7373
Fax: 856-247-7400
Email: cgp@virtua.org*

Dear Valued Patient,

This letter provides preparation instructions for your appointment for genetic counseling with the Cancer Genetics Program. Please read this letter prior to your appointment so you are prepared for your first visit. We look forward to helping you to Be Well, Get Well and Stay Well.

Sincerely,

Janice Christiansen, MS, LGC

Julie Handy, MS, LGC

Kathryn Zarnawski, MGC, LGC

PRIOR TO YOUR SCHEDULED APPOINTMENT:

- Please complete the enclosed forms as best as you can. If you do not know the answer to a certain question, leave it blank. Once completed, please mail, fax or email them back to us prior to your appointment. Some of the questions within the forms may not pertain to your genetic risk assessment but would be necessary for possible participation in a research opportunity. **If you do not send in your paperwork prior to your appointment, please arrive at least 30 minutes early.**
- If possible, include a copy of your pathology records or other documentation of your cancer or your non-cancer biopsies (if applicable). If possible, include reports for the cancers in your family members.
- If any family members had genetic testing related to cancer, **please include a copy of their test results or bring them with you to your appointment**. If you do not, your genetic testing, process may be delayed.
- Once your forms are completed and you have collected the necessary records, please send them to us using the contact information listed above.
- Please allow 2 hours for your appointment.**
- Please give us 48 hours advanced notice of cancellation.**

ON THE DAY OF YOUR VISIT:

- Bring a copy of the paperwork that you either mailed/emailed/faxed to us.
- Report to Outpatient Registration in suite E250:**

- i. Please bring with you: identification, your insurance cards, a copy of/or confirmation number for your referral or authorization (if required by your insurance) and the amount you are responsible to pay for the visit.
- ii. Referrals should be made out to Virtua Voorhees (Tax ID# 210634532) for 3 visits for genetic counseling (CPT Code 96040)

WHAT TO EXPECT DURING YOUR GENETIC COUNSELING APPOINTMENT:

- ❑ During your visit, the genetic counselor will review your medical and family history and help you understand the role of genes in causing cancer. We will discuss any concerns you may have about genetic testing as well as possible results, benefits, risks and limitations of the testing. We will also discuss cost, insurance coverage and current laws regarding the privacy of genetic information.
- ❑ If genetic testing is pursued, a blood draw is performed on site directly following your appointment. *You do not need to fast prior to your blood draw.*
- ❑ A follow up appointment with your genetic counselor will be scheduled at the time of your first visit. During the follow up appointment, we will review and discuss the results of your genetic testing. We will give you a general estimate of your personal cancer risks. We will discuss appropriate screening and prevention options for you and your family.

QUESTIONS ABOUT INSURANCE COVERAGE FOR GENETIC COUNSELING:

- ❑ The Voorhees Patient Access Team will contact your insurance for you to determine your benefits for genetic counseling. You will be contacted regarding your coverage and what responsibility you have for the visit. **This does not include costs for genetic testing.** It is possible to have coverage for genetic testing even if genetic counseling is not a covered service. **Your eligibility, the costs and preauthorization for genetic testing will be discussed at the time of your first visit.** If you have questions regarding your coverage or about referrals or authorizations, you may reach Voorhees Patient Access Team at 856-355-0292.

Directions for arrival for Cancer Genetics appointments

On the day of your Cancer Genetics appointment, you will report to Outpatient Registration located at 200 Bowman Drive, Suite E250, Voorhees, NJ 08043.

Directions:

From Points North

Take New Jersey Turnpike to Exit 4. Take Route 73 South. Stay on Route 73 South for approximately 5.7 miles. Pass the Route 73 and Kresson Road intersection. Turn right at the next traffic light onto Dutchtown Road. Turn left onto Howe Boulevard and proceed to Bowman Drive.

From Points South

Take Route 295 North to exit 34A onto Route 70 East. In 3.1 miles, take Route 73 South and proceed for 2.9 miles. Pass the Route 73 and Kresson Road intersection. Turn right at the next traffic light onto Dutchtown Road. Turn left onto Howe Boulevard and proceed to Bowman Drive.

Alternative Route from Points South

From the Atlantic City Expressway or Route 42

Take Berlin Cross Keys Road north to Route 73 North. Travel 3.4 miles and turn left at the traffic light onto Dutchtown Road. Turn left onto Howe Boulevard and proceed to Bowman Drive.

From Walt Whitman Bridge

When exiting the bridge, follow exit to Route 76 East. Proceed on Route 76 East to 295 North. Follow directions FROM POINTS SOUTH.

From Ben Franklin Bridge

Follow signs for Route 676 South, which becomes Route 76 East. Proceed on Route 76 East to Exit 295 North. Follow directions FROM POINTS SOUTH.

Bus Route

Route 451 stops at the hospital. For more information, call New Jersey Transit at (800) 772-2222.

Outpatient Registration is located adjacent to Virtua Voorhees Hospital in Area E. When you arrive on the hospital campus follow the signs to Neighborhood "E". Park in lot "E" and enter through the Main Lobby. Take the elevator to the second floor and follow the signs to Suite E250. Once you have registered, you will be directed to Suite D290 for your appointment. The Cancer Genetics Program office is located in the Penn Medicine Virtua Cancer Program office. If you are going to be late or are lost call us at 856-247-7373.

Cancer Genetics Program Health History Questionnaire

This form will provide us with important information about your health. Please fill in the blanks and boxes:

Your Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Male** **Female**

Who referred you? _____

Who is your:

Medical Oncologist:	Gynecologist:
Primary Care Doctor:	Radiation Oncologist:
Breast or Colorectal Surgeon:	Gastroenterologist:
Nurse Navigator:	Social Worker:

Your Concerns :

What is your primary reason for coming to the Risk Evaluation Program? _____

Are there any other concerns you would like addressed during your visit? _____

Genetic Testing:

Have you ever had genetic testing (related to hereditary cancer risk)? Yes No

If yes, which gene(s) were tested? _____

Has anyone in your family had genetic testing (related to hereditary cancer risk)? Yes No

If yes, which gene(s) were tested? _____

Has anyone in your family tested positive for a genetic mutation? Yes No

If yes, what gene mutation was discovered? _____

Where was the testing done? _____

****If yes for genetic testing for you or the family, please include copy of the test result. If you do not have a copy of your family member's results, genetic testing for you may be delayed.**

Current Marital Status:

- | | |
|---|---|
| <input type="checkbox"/> Married or Living as Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Never Married | <input type="checkbox"/> Domestic Partnership |
| <input type="checkbox"/> Other | <input type="checkbox"/> Unknown |

Your Current or Previous Occupation: _____

Highest level of school you have completed:

- | | |
|---|---|
| <input type="checkbox"/> 8 years or less | <input type="checkbox"/> Some college or technical school |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Graduated college |
| <input type="checkbox"/> High school grad/GED | <input type="checkbox"/> Graduate or professional school |
| | <input type="checkbox"/> Unknown |

Cancer History:

Have you ever had cancer? Yes No

If yes, please complete the following chart to include any cancer diagnosis. Specify Breast Cancer or DCIS if you know.
If you have had more than one cancer (e.g., bilateral breast cancer), please list both on this page:

Cancer Site/Type:	Example: Colon Cancer	Your First Cancer:	Your Second Cancer:
Laterality (Left/Right/Not Applicable)	Left	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Not Applicable	<input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Not Applicable
Date of Diagnosis	12/2000		
Age of Diagnosis	47		
Did you have Surgery for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Name of Procedure	Partial colectomy		
Surgery Date	1/5/2001		
Treatment Hospital	Virtua, Voorhees, NJ		
Did you receive Chemotherapy for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Type of Chemo	5FU and Oxaliplatin		
Date Chemo started	2/2001		
Treatment Hospital	Virtua, Voorhees, NJ		
Did you receive Radiation for this Cancer?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Date Radiation started			
Treatment Hospital			
Did you receive any other type(s) of therapy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Please specify.			
Date Other Therapy started			
Treatment Hospital			
Have you had a Recurrence with this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Date of Recurrence?	9/2002		
Where did this cancer recur? (example: lung, breast, liver)	Spread to Liver		
Treatment Hospital	Virtua, Voorhees, NJ		

***Chemo Drug List Examples**

Adriamycin (Doxorubicin)
Taxol (Paclitaxel)

Taxotere (Docetaxel)
Herceptin

Cytosan (Cyclophosphamide)
Avastin

Carboplatin
Other

Current Height: _____

Height at age 18: _____

Current Weight: _____

Weight at age 18: _____

Race/Ethnicity:

How would you describe your primary **racial background**? *Please check the appropriate boxes below.*

- | | |
|--|--|
| <input type="checkbox"/> Caucasian | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> African American | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> American Indian or Alaskan Native | <input type="checkbox"/> Multiple Races (Please Specify) _____ |

Most people in the United States have ancestors who come from other parts of the world. Some people have mixed ethnic backgrounds.

How would you describe your **FATHER’S** primary **ethnic background or country of origin**? (check one)

- | | |
|--|--|
| <input type="checkbox"/> Western/Northern Europe | <input type="checkbox"/> Southeast Asia |
| <input type="checkbox"/> Central/Eastern Europe | <input type="checkbox"/> Asia/Pacific Islander |
| <input type="checkbox"/> Africa | <input type="checkbox"/> Mexico |
| <input type="checkbox"/> Near East/Middle East | <input type="checkbox"/> Puerto Rico |
| <input type="checkbox"/> Latin America/Caribbean | <input type="checkbox"/> South America |
| <input type="checkbox"/> India | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asia | <input type="checkbox"/> Unknown |

How would you describe your **MOTHER’S** primary **ethnic background or country of origin**? (check one)

- | | |
|--|--|
| <input type="checkbox"/> Western/Northern Europe | <input type="checkbox"/> Southeast Asia |
| <input type="checkbox"/> Central/Eastern Europe | <input type="checkbox"/> Asia/Pacific Islander |
| <input type="checkbox"/> Africa | <input type="checkbox"/> Mexico |
| <input type="checkbox"/> Near East/Middle East | <input type="checkbox"/> Puerto Rico |
| <input type="checkbox"/> Latin America/Caribbean | <input type="checkbox"/> South America |
| <input type="checkbox"/> India | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Asia | <input type="checkbox"/> Unknown |

Are you or is anyone in your family of **Jewish decent**? No Yes ▶ Ashkenazi Sephardic Unknown

General Breast History:

Have you ever had a **physical breast exam** where the breasts are examined by touch to inspect for lumps? Yes No If yes, date of last physical breast exam: _____

Have you ever had a **mammogram**? Yes No
If yes, **age at first** Mammogram: _____ **Date of last** Mammogram: _____

Hospital/Location **last** Mammo: _____

Have you ever had a breast **MRI**? Yes No
If yes, **date of first** breast MRI: _____ **Date of last** breast MRI: _____
Hospital/Location **last** breast MRI: _____

Have you ever had a **breast ultrasound**? Yes No
If yes, **date of first** breast ultrasound: _____ **Date of last** breast ultrasound: _____
Hospital/Location **last** breast ultrasound: _____

Breast Biopsy History:

Have you ever had a breast **biopsy**? Yes No Not Sure
If yes, total number of breast biopsies you have had: _____

Benign Breast Biopsy Table:

Please list all biopsies with non-cancer results (your cancer history has already been collected on page 2). Please indicate in the table below your biopsy details.

Laterality (Left breast/Right breast/Both breasts)	Date of Biopsy	Hospital/Location	Result
<i>Example: Left breast</i>	<i>4/5/1996</i>	<i>Virtua, Voorhees</i>	<i>LCIS</i>
<i>Right breast</i>	<i>7/31/12</i>	<i>Virtua, Voorhees</i>	<i>Benign or normal</i>

Have you ever been diagnosed with any of the following **NON-CANCER breast conditions?** (Limit to List)
For Example:

- Atypical Hyperplasia
 Fibrocystic Disease
 Mammary Duct Ectasia
 Indeterminate diagnosis
 Fat Necrosis
 LCIS
 Mastitis
 I am uncertain
 Fibroadenoma
 Lipoma
 Other _____

Prophylactic Mastectomy History (Breast(s) removed NOT for cancer):

Have you had one or both of your **breasts removed (a mastectomy)** NOT for purposes of cancer treatment?
 Yes No If yes please complete the table below:

	Removed to prevent Cancer (Yes/No)	Removed for Other Reasons (Yes/No)	Date of Surgery	Hospital/Location
Right Breast				
Left Breast				

Do you have, or have you ever had, **breast implants?** Yes No
 If yes, was this for reconstruction after breast removal (a mastectomy)? Yes No

Cancer Prevention Medications:

Have you ever taken **Tamoxifen** (Nolvadex), **Raloxifene** (Evista), **Exemestane** (Aromasin) for cancer prevention? Yes No If yes please complete the table below:

	Month/Year Began	Age Began	Month/Year Stopped	Age Stopped
<i>Example: Tamoxifen</i>	<i>2/2000</i>	<i>47</i>	<i>Use presently</i>	<i>Use presently</i>

General Gynecologic History :

Have you ever had a **transvaginal ultrasound (TVUS)** of your ovaries? Yes No
 If yes, **date** and **hospital/location** of **first** TVUS: _____
Date and **hospital/location** of **last** TVUS: _____

Result of **last** TVUS: Benign/Normal Ovarian cyst(s) Cancer Other: _____

Have you had one or both of your **ovaries removed NOT for purposes of cancer treatment?** Yes No

If yes, please complete the table below:

	Removed to prevent Cancer (Yes/No)	Removed for Other Reasons (Yes/No)	Date of Surgery	Hospital/Location
Right Ovary				
Left Ovary				
Right Fallopian Tube				
Left Fallopian Tube				

Have you had your **uterus removed?** Yes No Not Sure

If so, Date of Surgery: _____

Hospital/Location: _____

Date of Last **Pelvic Exam:** _____

Have you ever had a PAP smear? Yes No Not Sure

If yes, **date of last** PAP smear: _____

Hospital/Location: _____

Have you ever had an abnormality on a PAP smear? Yes No Not Sure

If yes, **date of last** abnormal PAP smear: _____

General Hormone Use:

(Please record all periods of hormone usage, including intermittent stops.)

Hormone Related Contraceptives

Have you ever used contraceptive pills, injections (e.g., Depo-Provera), or implants (e.g., Norplant), intrauterine device (IUD) to prevent pregnancy or for any other reason? Yes No

If yes, please complete the table below:

Contraceptive	Month/Year Began	Age Began	Month/Year Stopped	Age Stopped	Reason for Taking
<i>Example: birth control pills</i>	6/1991	22	8/1995	26	Regulate menstrual cycle
<i>Example: Mirena IUD</i>	8/1996	27	(use presently)	(use presently)	contraception

Fertility Hormone Use:

Have you ever had a problem with infertility? Yes No

Have you ever taken infertility medication? Yes No

If yes, please complete the table below:

Hormone Name	Month/Year Began	Age Began	Month/Year Stopped	Age Stopped	Did you conceive a pregnancy using this medication?
<i>Example: Clomid</i>	5/1992	32	9/1992	32	Yes

Hormone Replacement Therapy (HRT) for Supplementation or Post Menopause

Have you ever taken HRT? Yes No

If so, what did you take?
(refer to table to the right)

- Estrogen alone
- Estrogen and Progestin
- Estrogen and Testosterone
- Not sure

Estrogen	Estrogen + Progestin	Estrogen + Testosterone
Premarin	Prempro	Estratest
Estradiol	Premphase	
	Prefest	
	Activella	
	Angeliq	

Month/Year Began	Age Began	Month/Year Stopped	Age Stopped
<i>Example: 11/1998</i>	<i>48</i>	<i>(use presently)</i>	<i>(use presently)</i>

Menstrual History:

Age at First Menstrual Period: _____

Have you had a menstrual period within the last year? Yes No

Age at last menstrual period: _____

Why have you not had your period within the last year?

- natural menopause
- chemotherapy, medication induced
- surgery on reproductive organs
- Mirena, IUD, Endometrial ablation, Depo-Provera
- breastfeeding
- Not Applicable
- other: _____

Pregnancies:

Have you ever been pregnant? Yes No Your age at first live birth: _____

If yes: How many times have you been pregnant? _____

Total number of live births: _____

Pregnancy	Date of End of Preg.	Outcome				Breast Feeding	
		Live birth	Still born	Miscarriage	Induced abortion	Yes/No	Months of breast feeding
<i>(Example)</i>	<i>11/13/1994</i>	<i>2 (twins)</i>				<i>Yes</i>	<i>3</i>
<i>(Example)</i>	<i>2/1996</i>			<i>1</i>		<i>-</i>	<i>-</i>
1							
2							
3							
4							
5							
6							

General Screening Tests and Outcomes for MEN and WOMEN:

Have you ever had a **bone density (DEXA) scan**? Yes No

If yes, **date of first** DEXA: _____ **Date of last** DEXA: _____

Hospital/Location **last** DEXA: _____

Please answer the following:

Osteopenia (mild to moderate bone loss) Ever Never If ever, date of diagnosis: _____

Hospital/Location you were diagnosed: _____

Osteoporosis (severe bone loss): Ever Never If ever, date of diagnosis: _____

Hospital/Location you were diagnosed: _____

Bone loss (not sure if osteoporosis or osteopenia) Ever Never If ever, date of diagnosis: _____

If you have been told you have osteoporosis or osteopenia, are you taking medication for it? Yes No

If yes, indicate medication name: _____

(examples: Actonel, Boniva, Fosamax, Reclast, Zometa, Forteo, Prolia)

Do you take calcium supplements? Yes No

Do you take vitamin D supplements? Yes No

Have you ever had a **colonoscopy? (colon cancer screening)** Yes No

Have you ever had a **sigmoidoscopy? (screening of the lower bowel for cancer)** Yes No

Total polyps _____ (can estimate)

Have you had any **adenomas** ("pre-cancerous" polyps)? Yes No I don't know

If you ever had a colonoscopy or sigmoidoscopy, please complete the table below. Please list any and all.

Screen Type	Date of screening	Total Polyps Reported	Outcome or Diagnosis: (negative/normal, hyperplastic polyps, adenomatous polyps, mixed polyps, malignant/cancer)	Hospital/Location
<i>EXAMPLE: colonoscopy</i>	<i>1/2/2011</i>		<i>(negative, polyp count and type, cancer)</i>	<i>Virtua Hospital, Voorhees, NJ</i>

Skin Biopsy History:

Have you ever had a **skin exam for cancer detection?** *(non-acne related etc.)* Yes No
 Have you ever been told you have **suspicious moles?** *(dysplastic skin lesion)* Yes No If yes Year _____
 Have you ever had a **skin biopsy?** Yes No Not Sure
 If yes, total number of skin biopsies you have had: _____

Have you ever been diagnosed with any of the following **NON-CANCER skin conditions?** *(Limit to List)*

- Keratoacanthoma Dysplastic Nevus Trichilemmoma
 Sebaceous Adenoma Papilloma Epidermal Cyst
 Melanoma-in-Situ Lipoma

Please indicate in the table below your biopsy details. Enter skin cancer-related procedures on pages 2-3.

Date of screening	Biopsy? (Yes/No)	Outcome	Hospital/Location
<i>EXAMPLE: 1/2/2011</i>	<i>Yes</i>	<i>Melanoma-in-situ</i>	<i>Pennsylvania Hospital</i>

Other Health Concerns:

Have you ever had a **cardiac stress test?** *(test during exercise to tell how your heart works during physical stress)*

Yes No

If yes, **date of first** test: _____ **Date of last** test: _____

Why was this test performed? _____

Hospital/Location: _____

Have you ever been told you have the following? *Please check all that apply.*

Medical Condition	Yes, have had this condition	Never had this condition	Age at Diagnosis	Have you ever taken/are you taking medication for it?
Coronary Artery Disease/Angina	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Congestive Heart Failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Myocardial Infarction (MI)/Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
High Blood Pressure (hypertension)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
High Cholesterol (hyperlipidemia)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Metabolic Syndrome or Insulin Resistance Syndrome	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Lymphedema (arm or leg swelling)	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Chronic, constant fatigue	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>
Other (Please specify):	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>

Smoking History:

Have you ever smoked cigarettes
(at least 1 pack per month for 1 year)? Yes No

What age did you start smoking regularly? _____

Do you still smoke? Yes No

If no, what age did you stop? _____

How many total years did you smoke (excluding periods of non-smoking)? _____

On average, how many packs did you smoke per day? _____
(1 pack = 20 cigarettes)

Alcohol:

Have you ever consumed alcohol? Yes No

In the past year on average how many drinks did you consume per week? _____

At maximal consumption, on average, how many drinks did you consume per week? _____

12 oz.	(1 can)	Beer
4 oz.	(glass)	Wine
1.25 oz.	(shot)	Liquor

Current Medications:

Do you take any medications regularly? Yes No

Please list names of medications here: _____

Personal History of Radiation Exposure (non-cancer related):

Bone x-ray	<input type="checkbox"/> Ever <input type="checkbox"/> Never	If ever, number of times before age 20: _____
Dental x-ray	<input type="checkbox"/> Ever <input type="checkbox"/> Never	If ever, number of times before age 20: _____
Chest x-ray	<input type="checkbox"/> Ever <input type="checkbox"/> Never	If ever, number of times before age 20: _____
CT Scan	<input type="checkbox"/> Ever <input type="checkbox"/> Never	If ever, number of times before age 20: _____

Patient reported information reviewed by:

Physician or Counselor Signature: _____

Date/Time: _____

***FOR MEN ONLY ***

Prostate Cancer Screening and Outcomes

Have you ever had a **digital rectal examination (DRE)**? Yes No

If yes, age at **first** DRE: _____

Age at **last** DRE: _____

Hospital/Location of last DRE: _____

Have you ever had a **PSA test**? Yes No

Age at **first** PSA: _____

Age at **last** PSA: _____

Result of last PSA test? Normal Abnormal Not Sure

Hospital/Location of last PSA: _____

Have you ever had a PSA >3ng/ml? Yes No Not Sure

Date : _____

Do you have a history of **prostatitis** (inflammation of prostate gland)? Yes No

Are you known to have **Benign Prostate Hyperplasia** (enlarged prostate)? Yes No

Have you ever had a **biopsy** of the prostate gland? Yes No

If yes, total number of biopsies you have had: _____

Please enter prostate cancer related surgery on pages 2-3.

Date of Biopsy	Hospital/Location
<i>Example</i> 4/5/1996	<i>Virtua, Voorhees, NJ</i>

Have you ever had any operations on your prostate gland not related to cancer? Surgical options include transurethral resection (TURP) and transurethral incision (TUIP).

If yes, please complete the table below. Surgeries for cancer go in the table on page 2 of this questionnaire.

Type of Operation	Reason for Surgery	Date of Surgery	Outcome	Hospital/Location
<i>Example: TURP</i>		2/3/11		<i>Virtua, Mt. Holly, NJ</i>

Have you ever had a **vasectomy**? Yes No

FAMILY HISTORY QUESTIONNAIRE

YOU AND YOUR PARENTS *Please estimate if exact dates are unknown.

YOU: <i>First Name:</i>	<i>Last Name:</i>	<i>Maiden:</i>
Date of Birth	____/____/____	
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
If YES: Location / Type of Cancer	_____	
Date of Diagnosis	____/____/____	
Hospital / Facility Where Diagnosed	_____	
YOUR MOTHER: <i>First Name:</i>	<i>Last Name:</i>	<i>Maiden:</i>
Date of Birth	____/____/____	Date of Death ____/____/____
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
If YES: Location / Type of Cancer	_____	
Date of Diagnosis	____/____/____	
Hospital / Facility Where Diagnosed	_____	
YOUR FATHER: <i>First Name:</i>	<i>Last Name:</i>	
Date of Birth	____/____/____	Date of Death ____/____/____
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A	
If YES: Location / Type of Cancer	_____	
Date of Diagnosis	____/____/____	
Hospital / Facility Where Diagnosed	_____	

YOUR GRANDPARENTS *Please estimate if exact dates are unknown.

YOUR MOTHER'S MOTHER: <i>First Name:</i> _____			<i>Last Name:</i> _____	<i>Maiden:</i> _____
Date of Birth	____/____/____	Date of Death	____/____/____	
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			
If YES: Location / Type of Cancer	_____			
Date of Diagnosis	____/____/____			
Hospital / Facility Where Diagnosed	_____			
YOUR MOTHER'S FATHER: <i>First Name:</i> _____			<i>Last Name:</i> _____	
Date of Birth	____/____/____	Date of Death	____/____/____	
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			
If YES: Location / Type of Cancer	_____			
Date of Diagnosis	____/____/____			
Hospital / Facility Where Diagnosed	_____			
YOUR FATHER'S MOTHER: <i>First Name:</i> _____			<i>Last Name:</i> _____	<i>Maiden:</i> _____
Date of Birth	____/____/____	Date of Death	____/____/____	
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			
If YES: Location / Type of Cancer	_____			
Date of Diagnosis	____/____/____			
Hospital / Facility Where Diagnosed	_____			
YOUR FATHER'S FATHER: <i>First Name:</i> _____			<i>Last Name:</i> _____	
Date of Birth	____/____/____	Date of Death	____/____/____	
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A			
If YES: Location / Type of Cancer	_____			
Date of Diagnosis	____/____/____			
Hospital / Facility Where Diagnosed	_____			

YOUR SIBLINGS

*Please estimate if exact dates are unknown.

Check here if you have no brothers or sisters and go to next page.

Do all of your brothers and sisters have the same mother and father? Yes No

SIBLING 1: First Name:		Last Name:		<input type="radio"/> BROTHER	<input type="radio"/> SISTER
Half Sibling?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>THROUGH YOUR</i>	<input type="checkbox"/> FATHER	<input type="checkbox"/> MOTHER	
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				
SIBLING 2: First Name:		Last Name:		<input type="radio"/> BROTHER	<input type="radio"/> SISTER
Half Sibling?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>THROUGH YOUR</i>	<input type="checkbox"/> FATHER	<input type="checkbox"/> MOTHER	
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				
SIBLING 3: First Name:		Last Name:		<input type="radio"/> BROTHER	<input type="radio"/> SISTER
Half Sibling?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>THROUGH YOUR</i>	<input type="checkbox"/> FATHER	<input type="checkbox"/> MOTHER	
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				
SIBLING 4: First Name:		Last Name:		<input type="radio"/> BROTHER	<input type="radio"/> SISTER
Half Sibling?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<i>THROUGH YOUR</i>	<input type="checkbox"/> FATHER	<input type="checkbox"/> MOTHER	
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				

YOUR CHILDREN

*Please estimate if exact dates are unknown.

Check here if you have no biological children and go to next page.

Do all your children have the same mother and father? Yes No If no, list other parent on bottom of page.

CHILD 1: First Name: _____		Last Name: _____		<input type="radio"/> SON	<input type="radio"/> DAUGHTER
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				
CHILD 2: First Name: _____		Last Name: _____		<input type="radio"/> SON	<input type="radio"/> DAUGHTER
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				
CHILD 3: First Name: _____		Last Name: _____		<input type="radio"/> SON	<input type="radio"/> DAUGHTER
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				
CHILD 4: First Name: _____		Last Name: _____		<input type="radio"/> SON	<input type="radio"/> DAUGHTER
Date of Birth	____/____/____	Date of Death	____/____/____		
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A				
If YES: Location / Type of Cancer	_____				
Date of Diagnosis	____/____/____				
Hospital / Facility Where Diagnosed	_____				

YOUR AUNTS AND UNCLES ON MOTHER'S SIDE *Please estimate if exact dates are unknown.

Check here if your mother had no brothers or sisters and go to next page.

Do all of your aunts and uncles on your mother's side have the same mother and father? Yes No

MOTHER'S SIBLING 1: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> UNCLE <input type="radio"/> AUNT
Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	
MOTHER'S SIBLING 2: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> UNCLE <input type="radio"/> AUNT
Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	
MOTHER'S SIBLING 3: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> UNCLE <input type="radio"/> AUNT
Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	
MOTHER'S SIBLING 4: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> UNCLE <input type="radio"/> AUNT
Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	

YOUR AUNTS AND UNCLAS ON FATHER'S SIDE *Please estimate if exact dates are unknown.

Check here if your father had no brothers or sisters and go to next page.

Do all of your aunts and uncles on your father's side have the same mother and father? Yes No

FATHER'S SIBLING 1: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> UNCLE <input type="radio"/> AUNT	
Date of Birth _____	_____ / _____ / _____ Date of Death _____ / _____ / _____
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
If YES: Location / Type of Cancer	_____
Date of Diagnosis	_____ / _____ / _____
Hospital / Facility Where Diagnosed	_____
FATHER'S SIBLING 2: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> UNCLE <input type="radio"/> AUNT	
Date of Birth _____	_____ / _____ / _____ Date of Death _____ / _____ / _____
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
If YES: Location / Type of Cancer	_____
Date of Diagnosis	_____ / _____ / _____
Hospital / Facility Where Diagnosed	_____
FATHER'S SIBLING 3: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> UNCLE <input type="radio"/> AUNT	
Date of Birth _____	_____ / _____ / _____ Date of Death _____ / _____ / _____
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
If YES: Location / Type of Cancer	_____
Date of Diagnosis	_____ / _____ / _____
Hospital / Facility Where Diagnosed	_____
FATHER'S SIBLING 4: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> UNCLE <input type="radio"/> AUNT	
Date of Birth _____	_____ / _____ / _____ Date of Death _____ / _____ / _____
Affected with Cancer?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A
If YES: Location / Type of Cancer	_____
Date of Diagnosis	_____ / _____ / _____
Hospital / Facility Where Diagnosed	_____

YOUR COUSINS

***Please estimate if exact dates are unknown.**

COUSIN 1: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> MALE <input type="radio"/> FEMALE	
Name of Related Parent (aunt/uncle) Who is this person related to? Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <input type="radio"/> UNCLE <input type="radio"/> AUNT <input type="radio"/> YOUR FATHER <input type="radio"/> YOUR MOTHER Date of Death _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____ _____
COUSIN 2: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> MALE <input type="radio"/> FEMALE	
Name of Related Parent (aunt/uncle) Who is this person related to? Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <input type="radio"/> UNCLE <input type="radio"/> AUNT <input type="radio"/> YOUR FATHER <input type="radio"/> YOUR MOTHER Date of Death _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____ _____
COUSIN 3: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> MALE <input type="radio"/> FEMALE	
Name of Related Parent (aunt/uncle) Who is this person related to? Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <input type="radio"/> UNCLE <input type="radio"/> AUNT <input type="radio"/> YOUR FATHER <input type="radio"/> YOUR MOTHER Date of Death _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____ _____

YOUR COUSINS (continued)

***Please estimate if exact dates are unknown.**

COUSIN 4: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> MALE <input type="radio"/> FEMALE	
Name of Related Parent (aunt/uncle) Who is this person related to? Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <input type="radio"/> UNCLE <input type="radio"/> AUNT <input type="radio"/> YOUR FATHER <input type="radio"/> YOUR MOTHER Date of Death _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____ _____
COUSIN 5: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> MALE <input type="radio"/> FEMALE	
Name of Related Parent (aunt/uncle) Who is this person related to? Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <input type="radio"/> UNCLE <input type="radio"/> AUNT <input type="radio"/> YOUR FATHER <input type="radio"/> YOUR MOTHER Date of Death _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____ _____
COUSIN 6: <i>First Name:</i> _____ <i>Last Name:</i> _____ <input type="radio"/> MALE <input type="radio"/> FEMALE	
Name of Related Parent (aunt/uncle) Who is this person related to? Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <input type="radio"/> UNCLE <input type="radio"/> AUNT <input type="radio"/> YOUR FATHER <input type="radio"/> YOUR MOTHER Date of Death _____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____ _____

YOUR NIECES AND NEPHEWS *Please estimate if exact dates are unknown.

NIECE / NEPHEW 1: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> NEPHEW <input type="radio"/> NIECE
Name of Related Parent _____ Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <i>THROUGH YOUR</i> <input type="radio"/> SISTER <input type="radio"/> BROTHER _____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____ _____	
NIECE / NEPHEW 2: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> NEPHEW <input type="radio"/> NIECE
Name of Related Parent _____ Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <i>THROUGH YOUR</i> <input type="radio"/> SISTER <input type="radio"/> BROTHER _____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____ _____	
NIECE / NEPHEW 3: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> NEPHEW <input type="radio"/> NIECE
Name of Related Parent _____ Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <i>THROUGH YOUR</i> <input type="radio"/> SISTER <input type="radio"/> BROTHER _____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____ _____	
NIECE / NEPHEW 4: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> NEPHEW <input type="radio"/> NIECE
Name of Related Parent _____ Date of Birth _____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____ Hospital / Facility Where Diagnosed _____	_____ <i>THROUGH YOUR</i> <input type="radio"/> SISTER <input type="radio"/> BROTHER _____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____ _____	

ADDITIONAL RELATIVES *Please estimate if exact dates are unknown.

RELATIVE 1: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> MALE <input type="radio"/> FEMALE
Relation to You _____ Date of Birth _____/_____/_____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____/_____/_____ Hospital / Facility Where Diagnosed _____	_____ _____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	
RELATIVE 2: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> MALE <input type="radio"/> FEMALE
Relation to You _____ Date of Birth _____/_____/_____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____/_____/_____ Hospital / Facility Where Diagnosed _____	_____ _____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	
RELATIVE 3: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> MALE <input type="radio"/> FEMALE
Relation to You _____ Date of Birth _____/_____/_____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____/_____/_____ Hospital / Facility Where Diagnosed _____	_____ _____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	
RELATIVE 4: <i>First Name:</i> _____ <i>Last Name:</i> _____		<input type="radio"/> MALE <input type="radio"/> FEMALE
Relation to You _____ Date of Birth _____/_____/_____ Affected with Cancer? If YES: Location / Type of Cancer _____ Date of Diagnosis _____/_____/_____ Hospital / Facility Where Diagnosed _____	_____ _____/_____/_____ Date of Death _____/_____/_____ <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A _____ _____/_____/_____	