Penn Medicine | Virtua Health

CANCER PROGRAM

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
Kathryn Zarnawski, MGC, LGC
Marisa Chamness, MS, LGC

PRIOR TO YOUR SCHEDULED APPOINTMENT:

- ❑ **Please complete the enclosed forms and mail, fax or email them back to us two weeks prior to your appointment. If forms are not received, we will need to reschedule your appointment.** If you do not know the answer to a certain question, leave it blank. 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 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.
- ❑ **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***.
- If you have genetic testing, we will review and discuss the results of your genetic testing with you once they are received. 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 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 856-355-0291.

<u>**Directions for arrival for Cancer Genetics appointments**</u>

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.

Penn Medicine | Virtua Health

CANCER PROGRAM

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:

☐ Married or Living as Married
☐ Divorced
☐ Never Married
☐ Other
☐ Separated
☐ Widowed
☐ Domestic Partnership
☐ Unknown

Your Current or Previous Occupation:______________________________

Highest level of school you have completed:

☐ 8 years or less
☐ Some high school
☐ High school grad/GED
☐ Some college or technical school
☐ Graduated college
☐ Graduate or professional school
☐ 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**	☐Left ☐Right ☐Not Applicable	☐Left ☐Right ☐Not Applicable
Date of Diagnosis	**12/2000**		
Age of Diagnosis	**47**		
Did you have **Surgery** for this Cancer?	☒Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐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?	☒Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐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?	☐Yes ☒No ☐Not Sure	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
Date Radiation started			
Treatment Hospital			
Did you receive any **other** type(s) of therapy?	☐Yes ☒No ☐Not Sure	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure
If yes: Please specify.			
Date Other Therapy started			
Treatment Hospital			
Have you had a **Recurrence** with this Cancer?	☒Yes ☐No ☐Not Sure	☐Yes ☐No ☐Not Sure	☐Yes ☐No ☐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)	Taxotere (Docetaxel)	Cytoxan (Cyclophosphamide)	Carboplatin
Taxol (Paclitaxel)	Herceptin	Avastin	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.*

- ☐ Caucasian
- ☐ Pacific Islander
- ☐ African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Hispanic
- ☐ Unknown
- ☐ 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 <u>country of origin</u>?** (check one)

- ☐ Western/Northern Europe
- ☐ Central/Eastern Europe
- ☐ Africa
- ☐ Near East/Middle East
- ☐ Latin America/Caribbean
- ☐ India
- ☐ Asia
- ☐ Southeast Asia
- ☐ Asia/Pacific Islander
- ☐ Mexico
- ☐ Puerto Rico
- ☐ South America
- ☐ Native American
- ☐ Unknown

How would you describe your **MOTHER'S** primary **ethnic background or <u>country of origin</u>?** (check one)

- ☐ Western/Northern Europe
- ☐ Central/Eastern Europe
- ☐ Africa
- ☐ Near East/Middle East
- ☐ Latin America/Caribbean
- ☐ India
- ☐ Asia
- ☐ Southeast Asia
- ☐ Asia/Pacific Islander
- ☐ Mexico
- ☐ Puerto Rico
- ☐ South America
- ☐ Native American
- ☐ 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
Example: *Left breast*	*4/5/1996*	*Virtua, Voorhees*	*LCIS*
Right breast	*7/31/12*	*Virtua ,Voorhees*	*Benign or normal*

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
Example: Tamoxifen	*2/2000*	*47*	*Use presently*	*Use presently*

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**
Example: birth control pills	*6/1991*	*22*	*8/1995*	*26*	*Regulate menstrual cycle*
Example: Mirena IUD	*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?**
Example: *Clomid*	*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
***Example**: 11/1998*	*48*	*(use presently)*	*(use presently)*

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:___________

		Outcome				Breast Feeding	
Pregnancy	**Date of End of Preg.**	***Live birth***	***Still born***	***Miscarriage***	***Induced abortion***	**Yes/No**	**Months of breast feeding**
(Example)	*11/13/1994*	*2 (twins)*				*Yes*	*3*
(Example)	*2/1996*			*1*		*-*	*-*
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
EXAMPLE: *colonoscopy*	*1/2/2011*		*(negative, polyp count and type, cancer)*	*Virtua Hospital, Voorhees, NJ*

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

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
EXAMPLE: *1/2/2011*	*Yes*	*Melanoma-in-situ*	*Pennsylvania Hospital*

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	☐	☐		☐
Congestive Heart Failure (CHF)	☐	☐		☐
Myocardial Infarction (MI)/Heart Attack	☐	☐		☐
Stroke	☐	☐		☐
High Blood Pressure (hypertension)	☐	☐		☐
High Cholesterol (hyperlipidemia)	☐	☐		☐
Metabolic Syndrome or Insulin Resistance Syndrome	☐	☐		☐
Diabetes	☐	☐		☐
Blood Clots	☐	☐		☐
Lymphedema (arm or leg swelling)	☐	☐		☐
Chronic, constant fatigue	☐	☐		☐
Memory Loss	☐	☐		☐
Depression	☐	☐		☐
Other (Please specify):	☐	☐		☐

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	☐Ever ☐Never	If ever, number of times before age 20: __________
Dental x-ray	☐Ever ☐Never	If ever, number of times before age 20: __________
Chest x-ray	☐Ever ☐Never	If ever, number of times before age 20: __________
CT Scan	☐Ever ☐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
Example *4/5/1996*	*Virtua, Voorhees, NJ*

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
Example: *TURP*		*2/3/11*		*Virtua, Mt. Holly, NJ*

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

FAMILY HISTORY QUESTIONNAIRE

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

YOU: *First Name:*	*Last Name:*	*Maiden:*
Date of Birth	_____/______/______	
Affected with Cancer?	☐ YES ☐ NO ☐ N/A	
If YES: Location / Type of Cancer	________________________	
Date of Diagnosis	_____/______/_______	
Hospital / Facility Where Diagnosed	________________________	
YOUR MOTHER: *First Name:*	*Last Name:*	*Maiden:*
Date of Birth	_____/______/______	Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A	
If YES: Location / Type of Cancer	________________________	
Date of Diagnosis	_____/______/_______	
Hospital / Facility Where Diagnosed	________________________	
YOUR FATHER: *First Name:*	*Last Name:*	
Date of Birth	_____/______/______	Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ 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: *First Name:*	*Last Name:* *Maiden:*
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
YOUR MOTHER'S FATHER: *First Name:*	*Last Name:*
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
YOUR FATHER'S MOTHER: *First Name:*	*Last Name:* *Maiden:*
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
YOUR FATHER'S FATHER: *First Name:*	*Last Name:*
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ 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:* ○ BROTHER ○ SISTER
Half Sibling?	☐ YES ☐ NO *THROUGH YOUR* ○ FATHER ○ MOTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
SIBLING 2: *First Name:*	*Last Name:* ○ BROTHER ○ SISTER
Half Sibling?	☐ YES ☐ NO *THROUGH YOUR* ○ FATHER ○ MOTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
SIBLING 3: *First Name:*	*Last Name:* ○ BROTHER ○ SISTER
Half Sibling?	☐ YES ☐ NO *THROUGH YOUR* ○ FATHER ○ MOTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
SIBLING 4: *First Name:*	*Last Name:* ○ BROTHER ○ SISTER
Half Sibling?	☐ YES ☐ NO *THROUGH YOUR* ○ FATHER ○ MOTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ 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:* ○ SON ○ DAUGHTER

Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________________

CHILD 2: *First Name:* *Last Name:* ○ SON ○ DAUGHTER

Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________________

CHILD 3: *First Name:* *Last Name:* ○ SON ○ DAUGHTER

Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________________

CHILD 4: *First Name:* *Last Name:* ○ SON ○ DAUGHTER

Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ 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: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
MOTHER'S SIBLING 2: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
MOTHER'S SIBLING 3: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________
MOTHER'S SIBLING 4: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	______________________________

YOUR AUNTS AND UNCLES 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: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________________
FATHER'S SIBLING 2: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________________
FATHER'S SIBLING 3: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________________
FATHER'S SIBLING 4: *First Name:*	*Last Name:* ○ UNCLE ○ AUNT
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ 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: *First Name:*	*Last Name:* ○ MALE ○ FEMALE
Name of Related Parent (aunt/uncle)	______________________ ○ UNCLE ○ AUNT
Who is this person related to?	○ YOUR FATHER ○ YOUR MOTHER
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	______________________

COUSIN 2: *First Name:*	*Last Name:* ○ MALE ○ FEMALE
Name of Related Parent (aunt/uncle)	______________________ ○ UNCLE ○ AUNT
Who is this person related to?	○ YOUR FATHER ○ YOUR MOTHER
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	______________________

COUSIN 3: *First Name:*	*Last Name:* ○ MALE ○ FEMALE
Name of Related Parent (aunt/uncle)	______________________ ○ UNCLE ○ AUNT
Who is this person related to?	○ YOUR FATHER ○ YOUR MOTHER
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	______________________

YOUR COUSINS (continued) ***Please estimate if exact dates are unknown.**

COUSIN 4: *First* Name:	*Last Name:* ○ MALE ○ FEMALE
Name of Related Parent (aunt/uncle)	________________ ○ UNCLE ○ AUNT
Who is this person related to?	○ YOUR FATHER ○ YOUR MOTHER
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	________________

COUSIN 5: *First* Name:	*Last Name:* ○ MALE ○ FEMALE
Name of Related Parent (aunt/uncle)	________________ ○ UNCLE ○ AUNT
Who is this person related to?	○ YOUR FATHER ○ YOUR MOTHER
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	________________

COUSIN 6: *First* Name:	*Last Name:* ○ MALE ○ FEMALE
Name of Related Parent (aunt/uncle)	________________ ○ UNCLE ○ AUNT
Who is this person related to?	○ YOUR FATHER ○ YOUR MOTHER
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	________________

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

NIECE / NEPHEW 1: *First Name:*	*Last Name:* ○ NEPHEW ○ NIECE
Name of Related Parent	____________ *THROUGH YOUR* ○ SISTER ○ BROTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________
NIECE / NEPHEW 2: *First Name:*	*Last Name:* ○ NEPHEW ○ NIECE
Name of Related Parent	____________ *THROUGH YOUR* ○ SISTER ○ BROTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________
NIECE / NEPHEW 3: *First Name:*	*Last Name:* ○ NEPHEW ○ NIECE
Name of Related Parent	____________ *THROUGH YOUR* ○ SISTER ○ BROTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________
NIECE / NEPHEW 4: *First Name:*	*Last Name:* ○ NEPHEW ○ NIECE
Name of Related Parent	____________ *THROUGH YOUR* ○ SISTER ○ BROTHER
Date of Birth	_____/______/______ Date of Death _____/_____/_____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	____________
Date of Diagnosis	_____/______/_______
Hospital / Facility Where Diagnosed	____________

ADDITIONAL RELATIVES *Please estimate if exact dates are unknown.

RELATIVE 1: *First Name:* *Last Name:* ○ MALE ○ FEMALE

Relation to You	______________________________
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	

RELATIVE 2: *First Name:* *Last Name:* ○ MALE ○ FEMALE

Relation to You	______________________________
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	

RELATIVE 3: *First Name:* *Last Name:* ○ MALE ○ FEMALE

Relation to You	______________________________
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	

RELATIVE 4: *First Name:* *Last Name:* ○ MALE ○ FEMALE

Relation to You	______________________________
Date of Birth	____/____/____ Date of Death ____/____/____
Affected with Cancer?	☐ YES ☐ NO ☐ N/A
If YES: Location / Type of Cancer	______________________________
Date of Diagnosis	____/____/____
Hospital / Facility Where Diagnosed	