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 advance notice of cancellation.

ON THE DAY OF YOUR VISIT:
- Bring a copy of the paperwork that you either mailed/printed/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.
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:  □ Married or Living as Married  □ Separated
□ Divorced  □ Widowed
□ Never Married  □ Domestic Partnership
□ Other  □ Unknown

Your Current or Previous Occupation:______________________________________________

Highest level of school you have completed:  □ 8 years or less
□ Some high school  □ Some college or technical school
□ High school grad/GED  □ Graduated college
□ Unknown  □ Graduate or professional school
**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:

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

*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 country of origin? (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 country of origin? (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.

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

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:

<table>
<thead>
<tr>
<th>Removed to prevent Cancer (Yes/No)</th>
<th>Removed for Other Reasons (Yes/No)</th>
<th>Date of Surgery</th>
<th>Hospital/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Breast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Breast</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Month/Year Began</th>
<th>Age Began</th>
<th>Month/Year Stopped</th>
<th>Age Stopped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Tamoxifen</td>
<td>2/2000</td>
<td>47</td>
<td>Use presently</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Removed to prevent Cancer (Yes/No)</th>
<th>Removed for Other Reasons (Yes/No)</th>
<th>Date of Surgery</th>
<th>Hospital/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right Ovary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Ovary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Right Fallopian Tube</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Left Fallopian Tube</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Month/Year Began</th>
<th>Age Began</th>
<th>Month/Year Stopped</th>
<th>Age Stopped</th>
<th>Reason for Taking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Mirena IUD</td>
<td>8/1996</td>
<td>27</td>
<td>(use presently)</td>
<td>(use presently)</td>
<td>contraception</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Hormone Name</th>
<th>Month/Year Began</th>
<th>Age Began</th>
<th>Month/Year Stopped</th>
<th>Age Stopped</th>
<th>Did you conceive a pregnancy using this medication?</th>
</tr>
</thead>
</table>

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
### 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: __________

<table>
<thead>
<tr>
<th>Pregnancy</th>
<th>Date of End of Preg.</th>
<th>Live birth</th>
<th>Still born</th>
<th>Miscarriage</th>
<th>Induced abortion</th>
<th>Breast Feeding</th>
<th>Months of breast feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Example)</td>
<td>11/13/1994</td>
<td>2 (twins)</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>(Example)</td>
<td>2/1996</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1</td>
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<td>3</td>
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<tr>
<td>4</td>
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<td>5</td>
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<tr>
<td>6</td>
<td></td>
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<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
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.

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

<table>
<thead>
<tr>
<th>Date of screening</th>
<th>Biopsy? (Yes/No)</th>
<th>Outcome</th>
<th>Hospital/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXAMPLE: 1/2/2011</td>
<td>Yes</td>
<td>Melanoma-in-situ</td>
<td>Pennsylvania Hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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

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: __________________________
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.

<table>
<thead>
<tr>
<th>Date of Biopsy</th>
<th>Hospital/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example 4/5/1996</td>
<td>Virtua, Voorhees, NJ</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Type of Operation</th>
<th>Reason for Surgery</th>
<th>Date of Surgery</th>
<th>Outcome</th>
<th>Hospital/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: TURP</td>
<td></td>
<td>2/3/11</td>
<td></td>
<td>Virtua, Mt. Holly, NJ</td>
</tr>
</tbody>
</table>

Have you ever had a vasectomy? ☐Yes ☐No
### FAMILY HISTORY QUESTIONNAIRE

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

<table>
<thead>
<tr>
<th>YOU: First Name:</th>
<th>Last Name:</th>
<th>Maiden:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affected with Cancer?</td>
<td>☐ YES ☐ NO ☐ N/A</td>
<td></td>
</tr>
<tr>
<td>If YES: Location / Type of Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of Diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital / Facility Where Diagnosed</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>YOUR MOTHER: First Name:</th>
<th>Last Name:</th>
<th>Maiden:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>☐/☐/☐</td>
<td>☐/☐/☐</td>
</tr>
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</table>
YOUR GRANDPARENTS  *Please estimate if exact dates are unknown.

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<thead>
<tr>
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<th>Last Name:</th>
<th>Maiden:</th>
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</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td><em><strong>/</strong></em>/____</td>
<td>Date of Death <em><strong>/</strong></em>/____</td>
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<td>□ YES □ NO □ N/A</td>
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</tr>
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<td>□ YES □ NO □ N/A</td>
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</tr>
<tr>
<td>Hospital / Facility Where Diagnosed</td>
<td>___________________</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>SIBLING 1: First Name:</th>
<th>Last Name:</th>
<th>☐ BROTHER ☐ SISTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half Sibling?</td>
<td>☐ YES ☐ NO</td>
<td>THROUGH YOUR ☐ FATHER ☐ MOTHER</td>
</tr>
<tr>
<td>Date of Birth</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td>Date of Death <em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>Affected with Cancer?</td>
<td>☐ YES ☐ NO ☐ N/A</td>
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<tr>
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</table>

<table>
<thead>
<tr>
<th>SIBLING 2: First Name:</th>
<th>Last Name:</th>
<th>☐ BROTHER ☐ SISTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half Sibling?</td>
<td>☐ YES ☐ NO</td>
<td>THROUGH YOUR ☐ FATHER ☐ MOTHER</td>
</tr>
<tr>
<td>Date of Birth</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td>Date of Death <em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>Affected with Cancer?</td>
<td>☐ YES ☐ NO ☐ N/A</td>
<td></td>
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<tr>
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<table>
<thead>
<tr>
<th>SIBLING 3: First Name:</th>
<th>Last Name:</th>
<th>☐ BROTHER ☐ SISTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Half Sibling?</td>
<td>☐ YES ☐ NO</td>
<td>THROUGH YOUR ☐ FATHER ☐ MOTHER</td>
</tr>
<tr>
<td>Date of Birth</td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
<td>Date of Death <em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
<tr>
<td>Affected with Cancer?</td>
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<td></td>
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<tr>
<td>If YES: Location / Type of Cancer</td>
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<tr>
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<table>
<thead>
<tr>
<th>SIBLING 4: First Name:</th>
<th>Last Name:</th>
<th>☐ BROTHER ☐ SISTER</th>
</tr>
</thead>
<tbody>
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<td>☐ YES ☐ NO</td>
<td>THROUGH YOUR ☐ FATHER ☐ MOTHER</td>
</tr>
<tr>
<td>Date of Birth</td>
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</tr>
<tr>
<td>Affected with Cancer?</td>
<td>☐ YES ☐ NO ☐ N/A</td>
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<td></td>
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<tr>
<td>Hospital / Facility Where Diagnosed</td>
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</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>CHILD 1: First Name:</th>
<th>Last Name:</th>
<th>☐ SON</th>
<th>☐ DAUGHTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
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<tr>
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<tr>
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<table>
<thead>
<tr>
<th>CHILD 2: First Name:</th>
<th>Last Name:</th>
<th>☐ SON</th>
<th>☐ DAUGHTER</th>
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<table>
<thead>
<tr>
<th>CHILD 3: First Name:</th>
<th>Last Name:</th>
<th>☐ SON</th>
<th>☐ DAUGHTER</th>
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<tr>
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<tr>
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<table>
<thead>
<tr>
<th>CHILD 4: First Name:</th>
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<th>☐ DAUGHTER</th>
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</tbody>
</table>
YOUR AUNTS AND UNCLE'S 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

<table>
<thead>
<tr>
<th>MOTHER’S SIBLING 1: First Name:</th>
<th>Last Name:</th>
<th>☐ UNCLE</th>
<th>☐ AUNT</th>
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<tr>
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<th>☐ UNCLE</th>
<th>☐ AUNT</th>
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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

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**YOUR COUSINS**

*Please estimate if exact dates are unknown.*

### COUSIN 1: First Name:  
Last Name:  
○ MALE  ○ FEMALE

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<th>Name of Related Parent (aunt/uncle)</th>
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YOUR COUSINS (continued)  *Please estimate if exact dates are unknown.*

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

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### ADDITIONAL RELATIVES

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<td><em><strong>/</strong></em>__/____</td>
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<tr>
<td>Hospital / Facility Where Diagnosed</td>
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