Familial Cancer Risk Assessment Center

<u>Please complete the information in this packet and return it PRIOR to your appointment with the Familial Cancer Risk Assessment Center.</u>

The information gathered from these questionnaires will be used to assess the possibility that the cancer in you and/or your family could be due to a hereditary cancer predisposition syndrome. It is important to realize that our recommendations are based on your recollection of your family history. Please let us know at your appointment if your family history of cancer changes, if you gather additional information, or if this information is recorded incorrectly as this may alter our impression or recommendations for your family.

We understand the packet asks for a great deal of information, please try your best to complete it.

If you have any questions about completing the questionnaires (medical and family history), please contact Rebecca Hodges, MS, genetic counselor, at 781-744-8834.

Please return the completed packet either by:

1) **Fax:** (see provided fax cover sheet) to Rebecca Hodges at 781-744-1660

2) **Mail:** Rebecca Hodges, MS, CGC
Lahey Clinic Medical Center
Department of General Surgery (6C)
41 Mall Road, Burlington, MA 01805

Name: ____
(First) **(Middle)** **(Last)**

Lahey Clinic # ____________ **Date of Birth:** _____ / _____ / _____

Referring Physician: _________________________ **Primary Care Physician:** _______________________

<u>Background</u>

Phone #: _________________________________ **Best time to call during business hours:** __________

Email (optional): ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired

Occupation: ____

Education level: _____________________________________

What is your race/ethnic background? If you are multiracial, check all that apply:

______ Caucasian ______ Black ______ Hispanic ______ Asian ______ Native American

Other (specify) ____

What Is you ancestry or country of origin (i.e. Italy, Greece, Japan)?

- Father's side: ____
- Mother's side: ____

Are you of Eastern European (Ashkenazi) Jewish descent? Yes__________ No__________

If yes, which side of the family (i.e. father, mother, both)? _________________________________

Are you adopted: Yes__________ No__________

Have you ever had a cancer diagnosis? Yes__________ No__________

If yes, what type(s) of cancer? _________________________________

How old were you when your cancer was diagnosed? _________________________________

If you have been diagnosed with cancer and have not been previously seen at Lahey Clinic, please bring a copy of your medical records to your appointment.

Family History Questionnaire Instructions

Please list all of your blood relatives, even if they have not had cancer. This information is very important and will shorten the amount of time spent reviewing your family history during the appointment.

If you are unable to determine exact ages, please *estimate* the age (i.e. in their early 40's). Please also include if any of your female relatives have had their uterus and/or ovaries removed (called a hysterectomy with or without salpingo-oophorectomy).

Please also be as specific as you can about the type of cancer in the individual. Many cancers start in one organ but spread to another – it is important to document the origin of the cancer, if possible. Also, please indicate if any of your relatives have had breast cancer in both breasts.

If you cannot fit all of your relatives on the form, please write additional information on the back page of the form or a separate sheet of paper. Please also feel free to include any great aunts, uncles, grandparents, or distant cousins with a history of cancer.

If you or any of your family members have ever had *genetic testing for cancer susceptibility*, please attach copies of the laboratory report(s) of your/their genetic test results to this questionnaire, or bring the report(s) with you at the time of your appointment. **We will need this information to order genetic testing for you.**

You, Your Parents, & Your Grandparents

Name (first name is sufficient)	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon Polyps? (If yes, see note below**)** Total # removed, age, & type)
You						
Your mother						
Your father						
Maternal Grandmother (your mother's mother)						
Maternal Grandfather (your mother's father)						
Paternal Grandmother (your father's mother)						
Paternal Grandfather (your father's father)						

****** Please indicate total number of polyps removed, age(s) at removal, and polyp type (i.e. benign, pre-cancerous, or unknown).***

Your Sisters & Brothers

Name	Alive or Deceased? (A/D)	Current Age or Age of Death	Did he/she have Cancer? (Y/N)	Type of Cancer	Age of Cancer Diagnosis	Colon polyps? (Total # removed, age, & type)
Sister 1						
Sister 2						
Sister 3						
Brother 1						
Brother 2						
Brother 3						
Half Sister 1 (same mother/father, please circle one)						
Half Sister 2 (same mother/father)						
Half Sister 3 (same mother/father)						
Half Brother 1 (same mother/father)						
Half Brother 2 (same mother/father)						
Half Brother 3 (same mother/father)						

Your Children

Name	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon polyps?** (Total # removed, age, & type)
Daughter 1						
Daughter 2						
Daughter 3						
Son 1						
Son 2						
Son 3						

Your Aunts & Uncles (on your mother's side)

Name	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon polyps?** (Total # removed, age, & type)
Mother's sister 1						
Mother's sister 2						
Mother's sister 3						
Mother's brother 1						
Mother's brother 2						
Mother's brother 3						

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

Name	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon polyps?** (Total # removed, age, & type)
Father's sister 1						
Father's sister 2						
Father's sister 3						
Father's brother 1						
Father's brother 2						
Father's brother 3						

Nieces & Nephews (children of your brothers & sisters)

Name	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon polyps?** (Total # removed, age, & type)
Niece 1 (parent name)						
Niece 2 (parent)						
Niece 3 (parent)						
Nephew 1 (parent)						
Nephew 2 (parent)						
Nephew 3 (parent)						

Cousins (children of your mother's brothers and sisters)

Name	**Gender (M/F)**	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon polyps?** (Total # removed, age, & type)
Cousin 1 (parent name)							
Cousin 2 (parent)							
Cousin 3 (parent)							
Cousin 4 (parent)							
Cousin 5 (parent)							
Cousin 6 (parent)							

Cousins (children of your father's brothers and sisters)

Name	**Gender (M/F)**	**Alive or Deceased? (A/D)**	**Current Age or Age of Death**	**Did he/she have Cancer? (Y/N)**	**Type of Cancer**	**Age of Cancer Diagnosis**	**Colon polyps?** (Total # removed, age, & type)
Cousin 1 (parent name)							
Cousin 2 (parent)							
Cousin 3 (parent)							
Cousin 4 (parent)							
Cousin 5 (parent)							
Cousin 6 (parent)							

Familial Cancer Risk Assessment Center

FACSIMILE TRANSMITTAL SHEET

TO: Rebecca Madore Hodges, MS, CGC	**FROM:**
COMPANY: Lahey Clinic Medical Center	**DATE:**
FAX NUMBER: 781-744-1660	**TOTAL NO. OF PAGES INCLUDING COVER:**
PHONE NUMBER: 781-744-8834	**SENDER'S FAX NUMBER:**
RE: Cancer Risk Evaluation Packet	**SENDER'S PHONE NUMBER:**

☐ URGENT ☐ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

NOTES/COMMENTS:

Your Appointment Date: ______________________________

CONFIDENTIAL

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