



*Please complete the information in this questionnaire and return it **PRIOR to your appointment** with the Familial Cancer Risk Assessment Center.*

The information gathered from this questionnaire will be used to assess the possibility that the cancer in you and/or your family is 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 impressions or recommendations for you and your family.

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

If you have any questions about completing the questionnaire, please contact Rebecca Hodges, MS, genetic counselor, at 781.744.8834.

**Please return the completed packet either by:**

- 1) Fax:** Rebecca Hodges at 781.744.1660 (see provided fax cover sheet)
- 2) Mail:** Rebecca Hodges, MS, CGC  
Lahey Hospital & Medical Center  
Department of General Surgery (6C)  
41 Mall Road, Burlington, MA 01805



<b>Name:</b> _____ (First) (Middle) (Last)
<b>Lahey Clinic #</b> _____ <b>Date of Birth:</b> ____ / ____ / ____

**Referring Physician:** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

**Background**

**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 your 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 not been seen previously at Lahey, please send a copy of your medical records with this questionnaire prior 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 (mother's mother)						
Maternal Grandfather (mother's father)						
Paternal Grandmother (father's mother)						
Paternal Grandfather (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

<b>Name</b>	<b>Alive or Deceased? (A/D)</b>	<b>Current Age or Age of Death</b>	<b>Did he/she have Cancer? (Y/N)</b>	<b>Type of Cancer</b>	<b>Age of Cancer Diagnosis</b>	<b>Colon polyps? (Total # removed, age, &amp; type)</b>
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***

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

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

<b>Name</b>	<b>Alive or Deceased? (A/D)</b>	<b>Current Age or Age of Death</b>	<b>Did he/she have Cancer? (Y/N)</b>	<b>Type of Cancer</b>	<b>Age of Cancer Diagnosis</b>	<b>Colon polyps? (Total # removed, age, &amp; type)</b>
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)***

<b>Name</b>	<b>Alive or Deceased? (A/D)</b>	<b>Current Age or Age of Death</b>	<b>Did he/she have Cancer? (Y/N)</b>	<b>Type of Cancer</b>	<b>Age of Cancer Diagnosis</b>	<b>Colon polyps? (Total # removed, age, &amp; type)</b>
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)***

<b>Name</b>	<b>Alive or Deceased? (A/D)</b>	<b>Current Age or Age of Death</b>	<b>Did he/she have Cancer? (Y/N)</b>	<b>Type of Cancer</b>	<b>Age of Cancer Diagnosis</b>	<b>Colon polyps? (Total # removed, age, &amp; type)</b>
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)***

<b>Name</b>	<b>Gender (M/F)</b>	<b>Alive or Deceased? (A/D)</b>	<b>Current Age or Age of Death</b>	<b>Did he/she have Cancer? (Y/N)</b>	<b>Type of Cancer</b>	<b>Age of Cancer Diagnosis</b>	<b>Colon polyps? (Total # removed, age, &amp; type)</b>
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)***

<b>Name</b>	<b>Gender (M/F)</b>	<b>Alive or Deceased? (A/D)</b>	<b>Current Age or Age of Death</b>	<b>Did he/she have Cancer? (Y/N)</b>	<b>Type of Cancer</b>	<b>Age of Cancer Diagnosis</b>	<b>Colon polyps? (Total # removed, age, &amp; type)</b>
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 Hospital & 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**



---

---

The document(s) accompanying this fax contain confidential information which is legally privileged. The information is intended only for the use of the recipient named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action with respect to the content of this faxed information except if directly delivered to the intended recipient named above is strictly prohibited. If you have received this fax in error, please notify us immediately by telephone and destroy the faxed document.

---

---