Patient & Family History Questionnaire

Name: _____ **DOB:** _____

Appointment Date and Time: _____

Please provide the following family history information in the tables below. Please include **all blood relatives** regardless of whether they have been diagnosed with cancer. It is also helpful to note if they complete screening (for example: mammogram, colonoscopy) and if they had any benign (non-cancerous) findings, for example: polyps (how many and type if possible). ***Please estimate within 5-10 years for each age requested on this form.***
When complete, return form via email, fax, or in person **at least one week prior to appointment,** to the following:

- ❑ Fax: Attention Julie Siefert at 410-553-8352
- ❑ Bring to: Julie Siefert at Dr. Urban's office, Aiello Breast Center

This information will allow appropriate preparation and review of family history to occur prior to your scheduled appointment.

If a family member has undergone genetic testing, please bring a copy of the results if possible.

Please note: It is important that you complete all **six (6) pages of this questionnaire.** The final page is specific to you only. Please contact us if you have any questions related to the form at 410-553-8152.

Here is an ***example*** of how to complete this form:

	Current Age OR Age at Death	Living OR Deceased?	Affected with cancer? Yes or No	Location of Cancer (example: Breast, Colon)	Age at Cancer Diagnosis	If genetic testing done, please indicate what testing was done.
You	*50*	*Living*	*Yes*	*Breast*	*45*	

YOU & YOUR PARENTS

	Current Age OR Age at Death	Living OR Deceased?	Affected with cancer? *Yes or No*	Location of Cancer *(example: Breast, Colon, etc.)*	Age at Cancer Diagnosis	If genetic testing done, please indicate what testing was done.
You		Living				
Your mother						
Your father						

Patient & Family History Questionnaire

YOUR SIBLINGS (your brothers and sisters)

Check One:	Current Age OR Age at Death	Living OR Deceased?	Affected with cancer? *Yes or No*	Location of Cancer *(example: Breast, Colon, etc.)*	Age at Cancer Diagnosis	If genetic testing done, please indicate what testing was done.
☐ Sister or ☐ Brother						
☐ Sister or ☐ Brother						
☐ Sister or ☐ Brother						
☐ Sister or ☐ Brother						
☐ Sister or ☐ Brother						
☐ Sister or ☐ Brother						

YOUR CHILDREN

Check One:	Current Age OR Age at Death	Living OR Deceased?	Affected with cancer? *Yes or No*	Location of Cancer *(example: Breast, Colon, etc.)*	Age at Cancer Diagnosis	If genetic testing done, please indicate what testing was done.
☐ Son or ☐ Daughter						
☐ Son or ☐ Daughter						
☐ Son or ☐ Daughter						
☐ Son or ☐ Daughter						
☐ Son or ☐ Daughter						
☐ Son or ☐ Daughter						

Patient & Family History Questionnaire

YOUR MATERNAL RELATIVES (your mother's family)

Relationship *If option, check one.*	**Current Age OR Age at Death**	**Living OR Deceased?**	**Affected with cancer?** *Yes or No*	**Location of Cancer** *(example: Breast, Colon, etc.)*	**Age at Cancer Diagnosis**	**If genetic testing done, please indicate what testing was done.**
Your mother's father						
Your mother's mother						
1. ☐ Aunt or ☐ Uncle						
2. ☐ Aunt or ☐ Uncle						
3. ☐ Aunt or ☐ Uncle						
4. ☐ Aunt or ☐ Uncle						
5. ☐ Aunt or ☐ Uncle						
6. ☐ Aunt or ☐ Uncle						

Other maternal relatives with cancer diagnoses: Please indicate relationship. For example, "Great Aunt, through maternal grandmother" or "Cousin, daughter of Aunt #4"

Relative	**Current Age or Age at death**	**Living or Deceased**	**Affected with Cancer? Yes or No**	**Location of Cancer (breast, colon, etc.)**	**Age at Cancer Diagnosis**
Relation: Please indicate exactly who they are related to: (you may draw arrow to relative in above chart) & genetic testing if done:					
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Patient & Family History Questionnaire

YOUR PATERNAL RELATIVES (your father's family)

Relationship *If option, check one.*	**Current Age OR Age at Death**	**Living OR Deceased?**	**Affected with cancer?** *Yes or No*	**Location of Cancer** *(example: Breast, Colon, etc.)*	**Age at Cancer Diagnosis**	**If genetic testing done, please indicate what testing was done.**
Your father's father						
Your father's mother						
1. ☐ Aunt or ☐ Uncle						
2. ☐ Aunt or ☐ Uncle						
3. ☐ Aunt or ☐ Uncle						
4. ☐ Aunt or ☐ Uncle						
5. ☐ Aunt or ☐ Uncle						
6. ☐ Aunt or ☐ Uncle						

Other maternal relatives with cancer diagnoses: Please indicate relationship. For example, "Great Aunt, through maternal grandmother" or "Cousin, daughter of Aunt #4"

Relative	**Current Age or Age at death**	**Living or Deceased**	**Affected with Cancer? Yes or No**	**Location of Cancer (breast, colon, etc.)**	**Age at Cancer Diagnosis**
Relation: Please indicate exactly who they are related to: (you may draw arrow to relative in above chart) & genetic testing if done:					
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Patient & Family History Questionnaire

Please list the country from which your family's ancestors came from.

Your Mother's mother	
Your Mother's father	
Your Father's mother	
Your Father's father	

Please list any additional history you would like to discuss at your appointment:

_____

_____

_____

_____

_____

_____

_____

Please note: ***If a family member has undergone genetic testing, please bring a copy of the results if possible.***

Patient Name: _____
Weight: _____
Height: _____

Ashkenazi Jewish
- ☐ Don't Know
- ☐ Prefer not to answer
- ☐ No
- ☐ Yes

Hispanic
- ☐ Don't Know
- ☐ Prefer not to answer
- ☐ No
- ☐ Yes

Smoking
- ☐ No, never
- ☐ Yes, but only in past
- ☐ Yes, currently

Alcohol
- ☐ None
- ☐ Less than 1 drink/week
- ☐ 1-4 drinks/ week
- ☐ 5-9 drinks/ week
- ☐ 10-19 drinks/ week
- ☐ More than19 drinks/ week

Breast Biopsies:
# of biopsies: ____
Abnormal Cells:
- ☐ Yes
- ☐ No
- ☐ Usure

Chest Wall Radiation Treatment:
- ☐ No
- ☐ Yes At Age: ____

For Female Patients Only:

Childbirth History:
# of pregnancies: ____
# of children: ____
Your age at first birth: ____

Currently Pregnant:
- ☐ I might be
- ☐ No
- ☐ Yes
- ☐ Fertility Drugs

Breast Feeding History
# of children: ____
# of months: ____
Months total: ____

Birth Control Use:
- ☐ No, never
- ☐ Not sure
- ☐ Yes, currently
- ☐ Yes, in the past

Details
Age stated birth control: _____
# of years taken: _____
Number of years taken continuously: ____

Currently Nursing
- ☐ No
- ☐ Yes

Menstrual History
Age of first period: ____
Still having periods:
- ☐ Yes
- ☐ No

Last Menstrual Period: _____
Are you sure?
- ☐ Yes
- ☐ No

Age Periods stopped: _____

Hormone Replacement Therapy:
Past Hormone Use:(Estrogen ONLY)
- ☐ No, Never
- ☐ Not sure
- ☐ Yes, currently
- ☐ Yes in past

Menopausal Status
- ☐ Peri-menopausal
- ☐ Post-menopausal
- ☐ Pre-menopausal
- ☐ Unknown

Hysterectomy:(uterus was taken out)
- ☐ No
- ☐ Yes Age: _____
- ☐ Not sure

Both Ovaries removed?
- ☐ No
- ☐ Yes Age: _____
- ☐ Not sure

Combined Hormone Use:
(Estrogen with progesterone)
- ☐ Yes _____
- ☐ No

Years Taken: _____
Intended Duration: ____
Years Since Taken: ____

Chemoprevention:

Tamoxifen:
- ☐ No, Never
- ☐ Not sure
- ☐ Yes, currently
- ☐ Yes in past

Raloxifene:
- ☐ No, Never
- ☐ Not sure
- ☐ Yes, currently
- ☐ Yes in past

Other:
- ☐ Aromasin
- ☐ Arimidex

This is the end of the questionnaire- Thank you!