Juravinski Hospital and Cancer Centre

CANCER GENETICS CLINIC
Juravinski Cancer Centre
699 Concession Street Hamilton, ON L8V 5C2
Tel 905.387.9711 Ext. 64636 Fax 905.575.6379
Booking Office: 905-521-2100 x43149
www.hamiltonhealthsciences.ca/cancergenetics

FAMILY HISTORY QUESTIONNAIRE

Your Name: _____

Date of Birth (D/M/Y): _____

Telephone (best number to reach you at): _____

May we leave a voice mail message at the above number? _____

Maiden Name: _____

Genetic Testing: Have you or any relatives had genetic testing? NO YES

If yes, please provide full name of relative: _____

Date of Birth (D/M/Y, if known): _____

Relationship to you (i.e. self, mother, father's sister): _____

Name/city of genetics clinic where you or your relative was tested: _____

Result (if known): _____

Instructions:

1. **Please fill out the following questionnaire to the best of your ability and send back prior to your appointment if possible.**
2. **If you were adopted please note that the information we need is about your biological family only.**
3. **If you don't know an answer, write "Don't Know" or "DK" in the space for the answer.**
4. **If necessary, please add a page with the additional information.**
5. **Please keep a copy of this document for your records.**

Please return these forms in one of the following ways:

- **by fax to 905-575-6379**
- **by mail to address above**
- **by email to cancergenetics@hhsc.ca (can be a saved file, scanned document or photo)**
  - *Precautions are taken to to make sure your personal health information is secure. However, with electronic communication (including email), there is a small risk of unauthorized disclosure of information.*

Please tell us about yourself:

Have you had cancer?	YES ☐ NO ☐	If yes, what type?	At what age?
Have you had bowel polyps removed?	YES ☐ NO ☐	If yes, how many?	At what age(s)?

Please tell us about your brothers, sisters and children:

Number of daughters:			
Number of sons:			
Number of full brothers:			
Number of full sisters:			
Number of half brothers:		**Same mother or same father?**	
Number of half sisters:		**Same mother or same father?**	

Please tell us about the history of cancer in your children, brothers and sisters (if applicable)

Relation to you Eg. Sister	**Full name (maiden name in brackets)** Pat (Smith) Doe	**Date of birth or current age** (D/M/Y)	**Date of Death or age at death** (D/M/Y)	**Type of Cancer** Ovary	**Age when diagnosed** 46

Please tell us about your mother:

Your Mother's Full name (maiden name in brackets)	**Date of birth or current age (D/M/Y)**	**Date of Death or age at death (D/M/Y)**	**Did your mother have cancer? (Please check)**	**If yes, what type of cancer did she have?**	**How old was she when she was diagnosed?**	**How many siblings does your Mother have? (indicate with a number)**
			YES ☐ NO ☐			___brothers ___ sisters

List any family members on your mother's side who have had cancer:

Relation to you (eg. aunt)	Full name (maiden name in brackets)	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Type of Cancer	Age when diagnosed

Please tell us about your father:

Your Father's Full name	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Did your father have cancer? (Please check)	If yes, what type of cancer did your father have?	How old was he when he was diagnosed?	How many siblings does your Father have? (indicate with a number)
			YES ☐ NO ☐			___brothers ___ sisters

List any family members on your father's side who have had cancer:

Relation to you	Full name (maiden name in brackets)	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Type of Cancer	Age when diagnosed