For Office Use Only

Genput Number#:_____Individual#_____

Appt Date-Time:_____

Please tell us about your health and your family's health. Knowing this helps the Genetics team tell you about risk for cancer, what genetic tests might help, and how you and your family can be as healthy as possible.

Please fax the completed form to **(804) 827-4100** or mail it to: Attn: Cancer Genetic Counselor; Department of Human and Molecular Genetics; Virginia Commonwealth University; P.O. Box 980033; Richmond, Virginia 23298-0033. Getting us the form before your appointment helps us to prepare. Or, you can bring it with you to the appointment.

General Information about You

1. Name:_____ 2. Referring Doctor_____

3. Date of Birth:_____ 4. Race:_____

5. *Father's* Ethnic Background/Ancestry_____ Any Jewish ancestry? □ Yes □ No

6. *Mother's* Ethnic Background/Ancestry_____ Any Jewish ancestry? □ Yes □ No

7. Your Highest Grade Completed:_____

8. What are you expecting from your genetic counseling appointment? _____
_____

9. How can we be most helpful to you?-
_____
_____

10. How do you like to learn health information (please check all that are right for you)?
- □ Talk to me about it
- □ Give me something in writing, like a brochure
- □ Give me some web sites
- □ Give me a video I can watch
- □ Connect me with other patients who have concerns like mine
- □ Other_____

11. How would you like to learn about cancer risks (please check all that are right for you)?
- □ Give me numbers, like percents
- □ Tell me how my risk compares to others
- □ Show me a graph
- □ Tell me if you think the risk is "high" or "low"
- □ Other_____

12. How likely do you think you are to get cancer? _____

13. On a scale from 0 ("no concern") to 10 ("extreme concern"), how concerned are you about your risk for cancer?_____

Your Health History

14. Have you or any of your blood relatives ever had genetic testing? ☐Yes* ☐No
    **If yes, it can be very helpful for us to review a copy of the test results. If possible, please attach the report to this form or bring the information to your appointment.*

15. Have you had cancer? ☐Yes ☐No
    a. How old were you when you were diagnosed?_____
    b. What type?_____
    c. What kinds of treatment did you have?_____

16. About how many servings of fruits and vegetables do you eat on a typical day?
    ☐ Fewer than 3
    ☐ 3 or 4
    ☐ At least 5

17. How much do you weigh? ____ pounds 26. How tall are you? ____ feet ____ inches

18. Have you smoked at least 100 cigarettes in your life? ☐Yes ☐No
    If yes, when? From_____ to_____

19. On average, do you currently drink more than one alcoholic drink per day? ☐Yes ☐No

20. Do you exercise on most days of the week? ☐Yes ☐No

21. Have you ever had a blistering sunburn? ☐Yes ☐No

22. Have you had any recent changes in bumps, moles, or spots on your skin? ☐Yes ☐No
    If yes, have you seen a dermatologist? ☐Yes ☐No

23. Have you ever had colon or intestinal polyps? ☐Yes ☐No
    If yes, how old were you? _____years
    How many total polyps have you had?_____

<u>Women</u>

24. When did you have your first period? _____years old

25. How old were you when you had your first child? _____years ☐ I have not had children

26. If you have had children, did you breastfeed them? ☐Yes ☐No ☐ I have not had children

27. Have you had your uterus, womb, or ovaries removed? ☐Yes ☐No
    a. What was removed?_____
    b. If yes, how old were you when it was removed? _____years old
    c. Why was this surgery performed?_____

28. Have you started change of life (menopause)? ☐Yes ☐No
    If yes, at what age? _____years old

29. Have you ever used oral contraceptives? ☐Yes ☐No
    If yes, when? From_____ to_____

30. Have you ever used medicine to prevent cancer? ☐Yes ☐No
    If yes, what did you take?_____ From_____ to_____

31. How many breast biopsies have you had?
    ☐ None
    ☐ 1
    ☐ More than 1

32. If you have had a breast biopsy, did any show "atypical hyperplasia"? ☐Yes ☐No ☐Unsure

Your Cancer Screening:

Exam	Yes	No	How Often?
33. Digital Rectal Exam	☐	☐	_____
34. Sigmoidoscopy	☐	☐	_____
35. Colonoscopy	☐	☐	_____
36. Barium Enema	☐	☐	_____
37. Fecal Occult Blood Test	☐	☐	_____
Women			
38. Breast Self Examination	☐	☐	_____
39. Clinical Breast Exam	☐	☐	_____
40. Mammography	☐	☐	_____
41. Breast MRI	☐	☐	_____
42. Transvaginal Ultrasound	☐	☐	_____
43. CA-125 Evaluation	☐	☐	_____
44. Endometrial Biopsy	☐	☐	_____
45. Pap Test	☐	☐	_____
Men			
46. PSA Evaluation	☐	☐	_____
47. Testicular Examination	☐	☐	_____

Your Family History

48. Please tell us about your BLOOD RELATIVES: a blood relative is your mother, father, child, brother, sister, half-brother, half-sister, uncle, aunt, niece, nephew, grandfather, grandmother, or first cousin. Have any of your BLOOD RELATIVES ever been told that they have a growth, tumor, or cancer that began (not where it spread) in the part of the body listed below?

Relative	Is this relative on your mother's or your father's side of the family?		Kind of cancer	Age at diagnosis	Current age (or age at death)	Still Living ?
	Mother's	*Father's*				
Example: Grandmother	[X]	[ ]	*Colon*	*42*	*45*	*No*
	[ ]	[ ]				
	[ ]	[ ]				
	[ ]	[ ]				
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	[ ]	[ ]				
	[ ]	[ ]				
	[ ]	[ ]				
	[ ]	[ ]				

49. How many full **brothers** do you have (include those who have died)?_____
How many *maternal* half-brothers?_____
How many *paternal* half-brothers?_____

50. How many full **sisters** do you have (include those who have died)?_____
How many *maternal* half-sisters?_____
How many *paternal* half-sisters?_____

51. How many sons do you have?_____ How many daughters?_____

52. Is there any history of relatives marrying relatives in your family? □Yes □No

53. Do your relatives who have had cancer share any unique physical characteristics (e.g. birthmarks, distinct appearance, physical and/or mental disabilities)? □Yes □No