

## 1. Basic Information

Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Address:	<input type="text"/>	<i>Middle</i>	<i>Maiden</i>	<i>Gender</i>	<i>Date of Birth</i>	<i>Your Place of Birth</i>
City/St/Zip:	<input type="text"/>	<input type="text"/>	<input type="text"/>	Country:	<input type="text"/>	
Phone:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<i>Home</i>	<i>Work</i>	<i>Cell</i>	<i>fax</i>	<i>Email</i>	<i>SSN</i>

Education Completed:	<input type="radio"/> None <input type="radio"/> Grade School <input type="radio"/> High School Degree	<input type="radio"/> Some College (1-3 yrs) <input type="radio"/> College Degree <input type="radio"/> Graduate School	Ethnicity:	<input type="checkbox"/> African-American <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian	<input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian/Pacific Islander
Current Status:	<input type="radio"/> Never Married <input type="radio"/> Married <input type="radio"/> Divorced	<input type="radio"/> Widowed <input type="radio"/> Partnered <input type="radio"/> Other	<b>Detailed Ethnicity</b>	Pat Grandfather Pat Grandmother Mat Grandfather Mat Grandmother (Please enter the countries where your grandparents came from.)	<input type="text"/>
Current or Former Occupation:	<input type="text"/>	Religion (if any):	<input type="text"/>		
Total family income for last year:	<input type="radio"/> Less than \$10,000 <input type="radio"/> \$10,000-\$19,999	<input type="radio"/> \$20,000-\$29,999 <input type="radio"/> \$30,000-\$39,999	<input type="radio"/> \$40,000-\$49,999 <input type="radio"/> More than \$50,000	Current Employment Status:	<input type="radio"/> Full-Time <input type="radio"/> Part-Time <input type="radio"/> Unemployed <input type="radio"/> Disabled <input type="radio"/> Retired
Medical Insurance Carrier:	<input type="text"/>	Type:	<input type="text"/>	Member #:	<input type="text"/>
Do you wish to cover your visits through your insurance?	<input type="radio"/> Yes <input type="radio"/> No		Have you received authorization for your visit?	<input type="radio"/> Yes <input type="radio"/> No	

Primary Care MD					
Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<i>First</i>	<i>Last</i>	Address:	City	State Zip Code
Phone:	<input type="text"/>	Fax:	<input type="text"/>	Email:	<input type="text"/>

Specialty Care MD					
Specialty :	<input type="text"/>				
Name:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<i>First</i>	<i>Last</i>	Address:	City	State Zip Code
Phone:	<input type="text"/>	Fax:	<input type="text"/>	Email:	<input type="text"/>

Do you have any particular concerns you would like to discuss with a genetic counselor?

## 2. Your Vital Statistics and Birth History

What was your BIRTH weight (lbs)?  How TALL are you (ft in)?  What is your CURRENT WEIGHT(lbs)?

What is the MOST you have ever weighed, excluding pregnancy (lbs)?

What did you weigh (lbs) when were you when you were 18 YEARS old? If you cannot remember, what was your dress size?

Was your mother a SMOKER when pregnant with you?  Yes  No  Unknown

Did your mother take DES (diethylstilboestrol, a drug to prevent miscarriage) when pregnant with you?  Yes  No  Unknow

## 3. Your Cancer History

Have you ever been diagnosed with cancer?  Yes  No

If YES, please complete the information below:

TYPE OF SURGERY E.G. LUMPECTOMY, QUADRANTECTOMY, MASTECTOMY, LAPAROTOMY, HYSTERECTOMY, COLECTOMY etc

SITE	TYPE OF CANCER	AGE	YEAR OF DIAGNOSIS	TYPE OF SURGERY	HOSPITAL	CITY	STATE

## 4. Your Past Medical History

Has a doctor ever told you that you have any of the following medical problems?

Hypertension.....	<input type="radio"/> Yes <input type="radio"/> No	Gallstones.....	<input type="radio"/> Yes <input type="radio"/> No
Diabetes.....	<input type="radio"/> Yes <input type="radio"/> No	Peptic ulcer.....	<input type="radio"/> Yes <input type="radio"/> No
Emphysema.....	<input type="radio"/> Yes <input type="radio"/> No	Arthritis.....	<input type="radio"/> Yes <input type="radio"/> No
Chronic bronchitis.....	<input type="radio"/> Yes <input type="radio"/> No	Diverticulitis or diverticulosis .....	<input type="radio"/> Yes <input type="radio"/> No
Coronary heart disease.....	<input type="radio"/> Yes <input type="radio"/> No	High levels of cholesterol.....	<input type="radio"/> Yes <input type="radio"/> No
Stroke of transient ischemic attack (TIA).....	<input type="radio"/> Yes <input type="radio"/> No	Hyperthyroidism.....	<input type="radio"/> Yes <input type="radio"/> No
Chronic pancreatitis	<input type="radio"/> Yes <input type="radio"/> No	Hypothyroidism.....	<input type="radio"/> Yes <input type="radio"/> No
Hepatitis.....	<input type="radio"/> Yes <input type="radio"/> No	Auto-immune illness.....	<input type="radio"/> Yes <input type="radio"/> No
Hemorrhoids.....	<input type="radio"/> Yes <input type="radio"/> No	Immune deficiency syndrome.....	<input type="radio"/> Yes <input type="radio"/> No
Kidney disease.....	<input type="radio"/> Yes <input type="radio"/> No	History of depression.....	<input type="radio"/> Yes <input type="radio"/> No
		Other psychological conditions.....	<input type="radio"/> Yes <input type="radio"/> No

### 4. Your Past Medical History continued

Please list any medical conditions (eg diabetes, high blood pressure, asthma etc) that you take/have taken medications to treat either currently or in the past. Please give the drug name, the dose and the length of time you have taken the drug regularly

NAME OF MEDICAL CONDITION	AGE DIAGNOSIS	WHAT DRUG TREATMENT, IF ANY?	DOSE mg/day	TIME ON THIS DRUG (years)

Have you had any surgeries, injuries, traumas or broken bones?  Yes  No

SURGERY OR INJURY	REASON FOR THE SURGERY	YEAR

Have you ever had one or more of the following gastro-intestinal examinations listed below:

Have you ever had a sigmoidoscopy?  Yes  No      Have you ever had a colonoscopy?  Yes  No

If YES to either, please fill in information below:

COLON or SIGMOID EXAM?	Number of POLYPS	DATE	HOSPITAL	CITY	STATE

Have you ever had a Barium Enema?  Yes  No      If YES, give a date of most recent examination

Have you ever had an upper GI endoscopy?  Yes  No      If YES, what was the result?

## 5. Skin Cancer Risks

What is your SKIN color?  Very Fair  Moderately Fair  Medium  Dark or Olive

What is your NATURAL hair color?  Blond  Red  Light Brown  Dark Brown or Black

What is your EYE color?  Blue  Green, Grey or Golden  Hazel  Brown or Black

How many times did you suffer from BLISTERING SUN BURN before the age of 20y?

Have you ever used a UV tanning bed regularly?  Yes  No

If YES, time using a tanning bed if used regularly  1/week for < 1 year  1/week for 5 - 10 years  
 1/week for 1 - 5 years  1/week for 10 - 20 years

How many MOLES do you have?  10 or fewer  >10  >20  >50  >100

Have you ever had any SKIN LESIONS, lumps or cysts removed? eg. basal cell carcinomas, squamous cell carcinomas, melanomas, lipomas, atypical moles, solar keratoses etc.  Yes  No

TYPE OF SKIN LESION	AGE	DATE AND HOSPITAL WHERE REMOVED

## 6. Life Style and Dietary History

### Tobacco

Do you SMOKE?  Yes  No  Cigarettes  Pipe  Cigars  Chewing Tobacco  Snuff  If CIGARETTES, how many do you smoke a day?

Have you EVER smoked?  Yes  No  Cigarettes  Pipe  Cigars  Chewing Tobacco  Snuff  Total # years smoked

If YES, at what age did you START smoking?  At what age did you STOP smoking?  How many cigarettes per day?

If you are a life-long NON SMOKER, have you ever lived with a smoker?  Yes  No  If YES, for how many years?

## 6. Life Style and Dietary History continued

### Alcohol

Do you drink alcohol?  Yes  No If YES, how many units per week? 1 unit = 1 glass of wine, 1 bottle of beer or 1 ounce of liquor

Have you drunk more than this in the past?  Yes  No

If YES, how many units per week? 1 unit = 1 glass of wine, 1 bottle of beer or 1 ounce of liquor  How many years at this average?

### Diet and Exercise

How would you rate your physical activity?	strenuous exercise four or more days/week	4	exercise is inconsistent but more than 10 times/month	2	very little exercise	1
How often do you eat red meat?	never eat red meat	1	2 X per week or less	3	more than 2 X per week	5
How often do you eat poultry?	never eat poultry	1	2 X per week or less	3	more than 2 X per week	5
How would you classify the amount of fiber in your diet?	high fiber	5	medium fiber	3	low fiber	1
How would you classify the amount of fat in your diet?	high in fat	5	medium fat	3	low fat	1

Do you drink coffee regularly?  Yes  No How old were you when you started drinking coffee regularly?

Do you usually drink caffeinated or decaffeinated coffee?  caffeinated  decaffeinated

How many cups of coffee do you usually drink each day?

### Support Network

Are you using any of the following psychological/emotional support groups?

- Family and friends
- Professional individual counseling
- Support group

**7. FOR WOMEN ONLY - GYNECOLOGICAL AND BREAST HEALTH QUESTIONS:**

**Menarche**

At what AGE did your periods start?

Are/were your periods REGULAR?

 Yes  No

**Birth Control Pills**

Have you ever taken birth control pills ?

 Yes  No

If YES, please list below one line for each continuous use of each type of pill:

NAME OF PILL (IF KNOWN)

DATE STARTED

DATE STOPPED

REASON FOR STOPPING PILL


**Pregnancies**

Have you ever been pregnant?

 YES  NO

Please write the YEAR of each of your pregnancies and check the box for each pregnancy outcome.

If TWINS please write 'T' next to the YEAR of pregnancy

YEAR	MISCARRIAGE?	TERMINATION?	STILL BIRTH?	LIVE BIRTH?	LENGTH PREGNANCY weeks	BREAST FED?	TIME BREAST FED months

**Infertility Drugs**

Did you ever take any infertility drug(s)?

 Yes  No

INFERTILITY DRUG

YEAR TAKEN

MONTHS TAKEN OR CYCLES TAKEN


**7. FOR WOMEN ONLY - GYNECOLOGICAL AND BREAST HEALTH continued:**

Have you ever taken a drug while pregnant to prevent miscarriage?

Yes  No

If YES, name the drug taken

**Menopause**

Have you started your menopause?

Yes  No

Date of your last period

Was your menopause natural?

Yes  No

If your menopause was NOT natural please explain what happened in the box below:

**Hormone Replacement Therapy (estrogen and/or progesterone preparations)**

Have you ever had hormone replacement therapy?

Yes  No

If YES, please list below one line for each continuous use of HRT:

HRT BRAND OR TYPE	DATE TOOK	REASON TAKING FOR HRT	DATE STOPPED HRT	REASON FOR STOPPING HRT

**Hysterectomy**

Have you ever had a hysterectomy?

Yes  No

If YES, please give the date

**Oophorectomy**

Have you ever had both ovaries removed?

Yes  No

If YES, please give the date

Have you ever had one ovary removed?

Yes  No

If YES, what was the date of that surgery?

Have you ever had the other ovary removed?

Yes  No

If YES, what was the date of that surgery?

If you still have one or two ovaries, have you ever had screening for ovarian cancer?

Yes  No

If YES, what test(s) have you had?

NP pelvic exam

MD pelvic exam

vaginal USS

CA125

Date(s) of ovarian screening if any

Result

7. FOR WOMEN ONLY - GYNECOLOGICAL AND BREAST HEALTH continued:

**Breast Health**

Do you examine your own breasts?  Yes  No How often in the last six (6) months?

Have you ever had a mammogram?  Yes  No

If YES, how often do you normally have mammograms?

How old were you when you had your 1st mammogram?

How many mammograms have you had?

Have you ever seen a physician regarding a breast lump?  Yes  No If YES, how many times?

**Breast Biopsy**

Have you ever had a breast biopsy done?  Yes  No

If YES complete below, one line for each biopsy:

DATE	L or R	HOSPITAL	CITY	ST	PATHOLOGY						
					Fibrocystic Disease	Atypical Hyperplasia	DCIS	LCIS	CANCER	Unknown	OTHER eg, fibroadenoma

**Drugs to Prevent Breast Cancer**

Have you taken TAMOXIFEN or ANOTHER DRUG to prevent breast cancer or a recurrence of breast cancer?  Yes  No

TAMOXIFEN	or	OTHER eg ARIMIDEX	DATE STARTED	REASON STARTED	DATE STOPPED	REASON STOPPED

## 8. Environmental History

Please list all the places you have lived for three years or longer below. Start with the first place you lived as a child.

If you moved within the same city or town, count this only once.

CITY	STATE	COUNTRY	# YEARS

Please indicate if you have had **REPEATED** contact (i.e. contact everyday for at least three months) with any of the following materials in your work, around the home, in your hobbies or during other activities. NB.inclusion of a substance in this list does NOT mean it is known to increase cancer risk

Substance	Substance	Substance
Animals excluding pets <input type="checkbox"/>	Film developing fluids <input type="checkbox"/>	Pesticides, herbicides <input type="checkbox"/>
Arsenic containing compounds <input type="checkbox"/>	Glue <input type="checkbox"/>	Petroleum products (not gas) <input type="checkbox"/>
Asbestos (brake lining, insulation, fire proofing) <input type="checkbox"/>	Grain dust <input type="checkbox"/>	Plastics (eg.vinyl chloride) <input type="checkbox"/>
Asphalt <input type="checkbox"/>	Iron ore <input type="checkbox"/>	PCB (electrical transformers) <input type="checkbox"/>
Benzene, xylene or other solvents <input type="checkbox"/>	Lead compounds (solder) <input type="checkbox"/>	Radiation (not X rays) <input type="checkbox"/>
Beryllium (copper alloy for springs, electrical contacts) <input type="checkbox"/>	Metal dust/fumes <input type="checkbox"/>	Talcum powder <input type="checkbox"/>
Cadmium <input type="checkbox"/>	Mustard gas <input type="checkbox"/>	Trichloroethylene <input type="checkbox"/>
Chemical fertilizers <input type="checkbox"/>	Nickel alloys <input type="checkbox"/>	Hair spray <input type="checkbox"/>
Chromium compounds <input type="checkbox"/>	Nitrates or nitrites <input type="checkbox"/>	Insulation material <input type="checkbox"/>
Coal <input type="checkbox"/>	Paint or finish remover <input type="checkbox"/>	Uranium <input type="checkbox"/>
Dry cleaning solvents <input type="checkbox"/>	Paint products <input type="checkbox"/>	Zinc <input type="checkbox"/>
Dye <input type="checkbox"/>		<input type="checkbox"/>

Have you had any other environmental exposure that you believe may affect/have affected your health?


**Medical History of Your Family Part 1: You, Your Spouse, Your Parents and Your Grandparents**

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include only your biological relatives and your spouse. Do not include adoptive, foster or step parents. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **female relatives** please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Relative	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer Yes or No	Age diagnosis	Cancer organ	Age ovaries removed if ever
Self									
My Biological Mother									
My Biological Father									
My Mother's Mom									
My Mother's Dad									
My Father's Mom									
My Father's Dad									
My 1st Spouse									
My 2nd Spouse									

**Medical History of Your Family Part 2: Your Brothers and Sisters**

Please complete with the **full name and date of birth of all your siblings, living and deceased**. Please complete age or date of death where it is applicable. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born. For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **sisters**, please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Sister/Brother	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer Yes or No	Age diagnosis	Cancer organ	Age ovaries removed if ever

**Medical History of Your Family Part 3: Your Children**

Please complete with the **full name and date of birth of each child**. *Please complete age or date of death where it is applicable.*

For each child, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **daughters**, please indicate whether they ever had surgery **to remove their ovaries and at what age**.

Daughter/Son	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer?	Age diagnosis	Cancer organ	Age ovaries removed if ever

**Medical History of Your Family Part 4: Your Mother's Brothers and Sisters**

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include full and half siblings, do not include adopted siblings. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **aunts**, please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Aunt/Uncle	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer?	Age diagnosis	Cancer organ	Age ovaries removed if ever

**Medical History of Your Family Part 5: Your Father's Brothers and Sisters**

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. Include full and half siblings, do not include adopted siblings. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For each relative, please mark whether or not they have had cancer. For those with a history of cancer please fill the organ and/or the type of cancer where this is known.

For your **aunts**, please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Aunt/Uncle	First Name	Last Name	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer?	Age diagnosis	Cancer organ	Age ovaries removed if ever

**Medical History of Your Family Part 6: ANY OTHER RELATIVES WITH CANCER i.e. nieces, nephews, first or second cousins, great aunt/uncles etc**

Please complete with the **full name and date of birth of each family member**. Please complete age or date of death where it is applicable. If you do not know the exact date of birth, for example, try and give a reasonable estimate of the year in which they were born.

For your **female relatives**, please indicate whether the person concerned ever had surgery **to remove her ovaries and at what age, if known**.

Relationship to you NB Maternal or Paternal relative?	THE PARENTS of this person were	FIRST NAME LAST NAME	Birth Date	Age now	If dead, AGE death +YEAR death	Cancer Yes or No	Age diagnosis	Cancer organ	Age ovaries removed <i>if ever</i>

## PERMISSION FORM

I hereby agree to permit the Cancer Risk Program at the University of California, San Francisco to obtain my medical records, pathology slides, and tissue blocks from attending physicians and hospitals, in furtherance of the research studies they are conducting.

This signed permission form may also be used in obtaining the records and tissue blocks of close relatives who are deceased and whose medical records and tissue blocks I am authorized by law to release.

This is my personal contribution, freely given, for the furthering of biomedical research and for familial cancer risk status evaluation.

A duplicate copy is as valid as the original.

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Signature

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Date