



Shodair Children's Hospital

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CANCER FAMILY HISTORY

Patient's Name: _____ Today's Date: _____

Patient's Date of Birth: _____

Name of Person Providing Patient Information: _____

How long have you known the patient? _____

What is your relationship to the patient? _____

Your answers to these questions will help us with our assessment.

LIFESTYLE AND SOCIAL HISTORY:

Do you smoke? YES NO

How many cigarettes per day? _____ N/A

Do you drink alcohol? YES NO

How many drinks per week? _____ N/A

What do you do for a living? _____

Have you ever been exposed to large amounts of chemicals: If so, what and when?

PERSONAL CANCER HISTORY:

Have you ever had a diagnosis of cancer? YES NO

If yes, type(s) of cancer: _____

Age at diagnosis: _____

Treatment: _____

Have you ever had a pre-cancerous lesion or biopsy? YES NO

- Breast lump: YES NO
- Colon polyp: YES NO
- Cervical dysplasia: YES NO
- Other (Please describe): _____

What was the diagnosis? _____

Age at biopsy: _____

Do you have any unusual skin findings? YES NO

Do you have any unusual patterns of freckling? YES NO

If yes, please describe and give location: _____

SCREENING:

Do you undergo mammograms? YES NO

How often? _____

Please give date and description of any abnormal mammograms: _____

Do you undergo colonoscopy? YES NO

How often? _____

Please give date and description of any abnormal colonoscopies? _____

Other cancer screening? YES NO

What type: _____

How often? _____

Please give date and description of any abnormal screening tests: _____

FAMILY HISTORY

How many children have you had? _____ sons _____ daughters

Please list all children below:_____

First Name	Gender	Age	Cancer Type (if any)	Age Cancer Diagnosed	Living	Age of Death	Cause of Death
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Siblings

How many siblings do/did you have? _____ brothers _____ sisters

Please list all siblings below:_____

First Name	Gender	Age	Cancer Type (if any)	Age Cancer Diagnosed	Living	Age of Death	Cause of Death
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Maternal Family

Mother:

Maternal Aunts/Uncles:_____

Please list all of your maternal Aunts/Uncles:

First Name	Gender	Age	Cancer Type (if any)	Age Cancer Diagnosed	Living	Age of Death	Cause of Death
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Maternal Grandparents:

Please list your maternal grandparents:

First Name	Gender	Age	Cancer Type (if any)	Age Cancer Diagnosed	Living	Age of Death	Cause of Death
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Paternal Family

Father:

Paternal Aunts/Uncles:

Please list all of your paternal Aunts/Uncles:

First Name	Gender	Age	Cancer Type (if any)	Age Cancer Diagnosed	Living	Age of Death	Cause of Death
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Paternal Grandparents:

Please list your paternal grandparents:

First Name	Gender	Age	Cancer Type (if any)	Age Cancer Diagnosed	Living	Age of Death	Cause of Death
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No		

Does anyone in your family have any of the following conditions:

- | <u>Disorder</u> | <u>If yes, relationship to you:</u> |
|--|-------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Birth defect needing surgery? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mental retardation? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Autism? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Learning disability? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual skin findings? | _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Unusual freckling patterns? | _____ |

Does anyone not listed above have a history of cancer, developmental problems, or chronic health problems? Please describe problems and relationship to patient. _____

Do you have any specific concerns or questions with regard to your genetics consultation?
