THUNDER BAY Regional Health SCIENCES CENTRE

GENETICS PROGRAM

FAMILY HISTORY FORM (CANCER)

Place Patient Label with Barcode Here

Ped No. DATE: _____

Dear _____,

You have been referred to our department by _____ because of your personal and/or family history of cancer.

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM

- The purpose of this form is to allow us to make an assessment of your family history of cancer.
- We need to know which people in your family have had cancer, what sort of cancer they have had and the age at which they were diagnosed with cancer. **We also need to know about close relatives who have not had cancer.**
- Please complete this form, giving as much information as possible about your family. If there is any information you do not know, perhaps someone in your family will be able to help you, otherwise please leave the box empty.

All the information that you give will be held in confidence in the clinical genetics department and we will not contact any of your relatives without your permission.

Your Details:

Home Tel:	Daytime Tel:
Cellular Tel:	A good time to contact me between 8:30am and 4:30pm is:
Is it OK to leave a brief message if you are not available?: YES ☐ NO ☐	
Primary Health Care Professional (include address):	
Have you/your relatives seen a Geneticist in the past?: If yes, please provide details.	

ETHNIC ORIGIN – We ask this because some inherited cancers are more common in some ethnic groups

Father's Ethnic Background:_____ Mother's Ethnic Background:_____

Please return this form by _____. Please note we will not be able to offer an assessment of your risk of cancer or be able to process your referral until you return your completed questionnaire.

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Relative	Full Name (including maiden name and any previous names)	Date of Birth (or approximate year if unknown)	Alive (Y/N)	Date of Death (or approximate year if unknown)	If you or your relatives have/had cancer		
					Type of Cancer	Age at Diagnosis	Address at Diagnosis and/or Hospital where treated (or town/city if unknown)
Self							
Your Own Children *(circle as appropriate)	Son Daughter						
	Son Daughter						
	Son Daughter						
Your Sisters (Full or Half) If half please indicate which parent you share							
Your Brothers (Full or Half) If half please indicate which parent you share							
Your Mother							
Your Father							
Your Mother's Mother							
Your Mother's Father							
Your Father's Mother							
Your Father's Father							

Your Mother's Brothers and Sisters *(circle as appropriate)	Brother Sister						
	Brother Sister						
	Brother Sister						
	Brother Sister						
	Brother Sister						
Your Father's Brothers and Sisters *(circle as appropriate)	Brother Sister						
	Brother Sister						
	Brother Sister						
	Brother Sister						
	Brother Sister						

Please use this section to complete the details of any other relatives who have had any relevant birth defects, diseases or conditions who have not yet been asked for or there was not space for.

Relative	**Full Name** (including maiden name and any previous names)	**Date of Birth** (or approximate year if unknown)	**Alive** (Y/N)	**Date of Death** (or approximate year if unknown)	**If you or your relatives have/had cancer**		
					Type of Cancer	**Age at Diagnosis**	**Address at Diagnosis and/or Hospital where treated** (or town/city if unknown)

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