Integrated GENETICS
LabCorp Specialty Testing Group

Please complete this questionnaire prior to your Cancer Risk Assessment appointment. If you are uncertain about your family history, we encourage you to speak with relatives who may have more information. Please bring the completed form to your appointment, or return it to our office prior to your appointment if you have been given instructions to do so.

During the genetic counseling session, we will be asking about your parents, grandparents, great-grandparents, children, grandchildren, great-grandchildren, siblings, nieces/nephews, great-nieces/great-nephews, aunts/uncles, first cousins, and great-aunts/uncles on your maternal and paternal sides of the family. For each individual we will ask you to provide health status, the current age or age at death, cancer history and cause of death, as applicable.

Also please do your best to bring to the appointment any medical records (including pathology reports) documenting the specific diagnosis for any relative diagnosed with breast, ovarian, colon or other cancers as well as genetic test results.

Section 1. Patient Information

Name _____ Date of Birth _____ Sex F ☐ M ☐

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell _____ Occupation _____

Referring Physician's Name _____ Referring Physician's Phone Number _____

Questions 1-9 for WOMEN ONLY

1. At what age did your menstrual period begin? _____ 2. Are you still having periods? No ☐ Yes ☐

3. If you have children, how old were you at the birth of your first child? _____ 4. Have you had a mammogram? No ☐ Yes ☐

5. Have you ever used birth control pills? No ☐ Yes ☐ If YES for how many total years? _____

6. Did you use hormone replacement therapy (HRT)? No ☐ Yes ☐ If YES for how many total years? _____

7. Have you had any breast biopsies? No ☐ Yes ☐ If YES how many times? _____

If YES what was the result for each (for example atypical ductal hyperplasia) _____

8. Have you had either your breasts removed? No ☐ Yes ☐ Age if yes _____

9. Have you had your ovaries removed? No ☐ Yes ☐ Age if yes _____

Questions 10-12 Your cancer history

10. Have you ever been diagnosed with cancer? No ☐ If no, continue on to the next page Yes ☐ Complete below

11. How old were you at the time of the initial cancer diagnosis? ____ If you had subsequent diagnosis, at what age? _____

12. Describe the type of cancer, including cancer markers if known, such as ER (estrogen receptor), PR (progesterone receptor) or Her2/neu, and the specific location of the cancer (if more than 1 cancer diagnoses list all and specify if 2nd primary or metastasis): _____

Section 2. Family History **Complete all the information below about your family. Use a separate sheet if needed**

1. Information on your children, only if diagnosed with cancer

First Name	Present age	If deceased, age of death	Gender	Type of cancer and specific location, if known: If more than 1 cancer list all cancers and specify if 2nd primary or metastasis	Age at diagnosis
			M ☐ F ☐		
			M ☐ F ☐		
			M ☐ F ☐		

2. Please complete the following for your relatives diagnosed with cancer. i.e., parents, grandparents, great-grandparents, grandchildren, great-grandchildren, siblings, nieces/nephews, great-nieces/great-nephews, aunts/uncles, first cousins, great-aunts/uncles

Maternal side of the family

First Name	Present age	If deceased, give age of death	Type of cancer & specific location, if known. If more than 1 cancer list all cancers and specify if 2nd primary or metastasis	Age of cancer diagnosis	Relationship to you	If in breast, kidney, lung, ovaries or testicles did it occur in one or both sides?
						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐

Paternal side of the family

						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐
						One ☐ Both ☐

3. Have you or any of your family member(s) ever had genetic testing because of the cancer(s) in the family? ☐ No ☐ Yes

If Yes, specify who: _____ Results: _____

Additional comments: _____

_____

_____

Patient's signature _____ Date _____