Think about the main types of cancer in your family.

- What do you think your risk of developing cancer is compared with someone who does not have a family history of the disease.
  Much less ☐ Slightly less ☐ Same as ☐ Slightly higher ☐ Much higher ☐

- What do you think your chances are of developing this cancer in your lifetime? Please mark on the line with an arrow.

  No chance of getting cancer 0% ______ 50% ______ 100% Complete certainty of getting cancer

- What are your main questions which you would like to discuss with the Cancer Geneticist/Nurse?

  ____
  ____
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  ____

Please feel free to use a separate sheet of paper if you wish.

Please complete this section if you are a woman who has a family history of breast or ovarian cancer.

- At what age did your periods start?
- At what age did you go through menopause? ______________________(if appropriate)
- Are you taking the contraceptive pill? Yes ☐ No ☐
- For how many years of your life have you been on the contraceptive pill (if at all?)__________
- Are you taking Hormone Replacement Therapy (HRT)? Yes ☐ No ☐ If Yes, for how long? ______
- Have you ever had a scan of your ovaries Yes ☐ No ☐
  If yes when was your last one? ______________________
  Where was it done? ______________________
- Have you ever had a mammogram? Yes ☐ No ☐
  If yes, when was your last one? ______________________
  Where was it done? ______________________
- Have you ever had any problems with your breasts? If so please describe the nature of the problem including dates, hospitals attended and names of specialists seen.

  ____
  ____
  ____
  ____

  Please feel free to use a separate sheet of paper if you wish.

  Thank you for completing this questionnaire. Please return it to the above named address.

  If another copy is required please log on to our website **www.genetics.ie** to download another copy.

National Centre for Medical Genetics

Our Lady's Hospital for Sick Children
Crumlin, Dublin 12
Tel.: (01) 409 6722
Fax: (01) 456 0953
Website: www.genetics.ie

You have been referred to the Cancer Genetic Service because of a history of cancer in your family. We would be grateful if you would complete this questionnaire which will help us to assess whether or not your family history places you at an increased risk of cancer. We would ask you to return this questionnaire within the next 2-3 weeks.

Please attempt to complete as many sections as possible. The more details you can provide, the more accurate we can be in our assessment. It is important to include those family members (alive and deceased) **who have had**, as well as those **who have not had** cancer, as this will have a bearing on your overall cancer risk. **If any member of your family has been through the service please let us know as this could save you having to complete this questionnaire.**

Please complete all four pages and return the questionnaire as soon as possible. We will not be able to offer an assessment of your cancer risk, or process your referral, until we have received your completed questionnaire.

If you have any queries or difficulties in completing the questionnaire, please do not hesitate to contact us at the above number. If you are unable to complete all the sections, please return the form anyway.
Thank you

Name ______________	GP Name ______________
Date of birth ______________	GP Address ______________
Address ______________	______________
______________	______________
Postcode ______________	______________
Telephone Day ______________	Telephone No ______________
Evening ______________	☐ Please indicate here if you are **NOT** on the telephone

For office use only

Date received in Department

Genetic No:

Please complete the form below, giving as much information as possible about your immediate (blood) relatives, **including those who have NOT had cancer.**

If there is any information you do not know, perhaps someone in your family will be able to help you, otherwise leave that box empty. You may find it easier to start on the row that refers to your mother and complete all boxes relating to her before you start on the next member of your family. All the information you give will be held in confidence in the Clinical Genetics Centre.

Please continue onto additional sheets of paper if necessary.

Relative	**Name** (including maiden and any previous names) **and Last known address**	**D.O.B.**	Is the person still alive Yes/No	If they are dead what was their date of death	**If your relatives suffered from cancer.....** Which part of the body was affected by cancer	Age when cancer found	Hospitals where treated Please also give the name of specialist if known
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							
Your father's brothers and sisters							
Your brothers and sisters (including half brothers and sisters)							
Your own children							

Yourself

Do you smoke? Yes ☐ No ☐ If yes, how many per day? ____________

Some types of genetic cancer are slightly more common in Jewish families.
Are you, your partner or any of your immediate family Jewish? Yes ☐ No ☐

Are you and your partner blood related? for example, cousins? Yes ☐ No ☐

Have any of your relatives ever had a genetic test? Yes ☐ No ☐

If yes, give details ____________

____

Have you suffered from any major illnesses, in particular have you had any form of cancer yourself? Yes ☐ No ☐
If yes, please give details including dates, hospitals attended, names of specialists seen and any medication taken.

____

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Please feel free to use a separate sheet of paper if you wish.