

Cancer Genetics Unit Family History Questionnaire

When completing this form we just ask that you fill in as much as you know. Please keep a copy for your records to avoid difficulties if the original does not reach us. Please contact us on 020 8661 3375 if you have a query or difficulty completing this form, so we can help. This information will be treated as strictly confidential.

PLEASE RETURN FORM TO: Cancer Genetics Unit, The Royal Marsden NHS Foundation Trust, Downs Road, Sutton, Surrey SM2 5PT

First Name	Surname	Maiden Name
Date of Birth	Address	
	Postcode	

Have you seen a genetics service before?	Yes / No <i>(please circle)</i>	If yes, where
Has anyone in your family seen a genetic service? <i>(About cancer or any other genetic condition)</i>	Yes / No <i>(please circle)</i>	If yes, please specify which relative and where
Have you ever been diagnosed with cancer?	Yes / No <i>(please circle)</i>	If yes please give - a) cancer type <i>(ie.breast and state which side affected if applicable)</i> _____ b) your age/or the date of cancer diagnosis _____ c) the hospital(s) where you were seen

Please return this form by

or we will not be able to offer you an appointment without seeking a new referral

Office use	Date sent	Date received	Int/Ext/GP/C&B
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Ethnic Origin

This information can help us in clarifying risk as certain cancer risks are different in different populations.
Please tick appropriate boxes for each side of your family.

Mother's side of family		Father's side of family	
White	<input type="checkbox"/>	White	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
Black African	<input type="checkbox"/>	Black African	<input type="checkbox"/>
Indian	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Asian other	<input type="checkbox"/>	Asian other	<input type="checkbox"/>
East European	<input type="checkbox"/>	East European	<input type="checkbox"/>
Jewish	<input type="checkbox"/>	Jewish	<input type="checkbox"/>
Ashkenazi	<input type="checkbox"/>	Ashkenazi	<input type="checkbox"/>
Sephardic	<input type="checkbox"/>	Sephardic	<input type="checkbox"/>
Other ethnic group	<input type="checkbox"/>	Other ethnic group	<input type="checkbox"/>
<i>Please specify</i>		<i>Please specify</i>	

The information provided in this questionnaire will be reviewed by one of the Cancer Genetics Team. If appropriate a telephone or face to face appointment will be arranged.

Please indicate below, the number(s) you would like to be contacted on for a telephone appointment:

Home

Mobile

Work

I give permission to share information about cancer diagnoses in the family (in the form of a family tree) to other genetic centres upon request, in order to assist counselling of other relatives Yes No (*please tick*)

I give permission to store my Family History Questionnaire on my electronic patient records at the Royal Marsden NHS Foundation Trust Yes No (*please tick*)

Your signature

Your Family	Surname, First Name	Male/ Female	Date of Birth or year	Alive Yes/No	Date of Death or year	Cancer Yes/No	Cancer Type (eg. Breast and state which side affected if applicable)	Age at diagnosis or year	Hospital where treated (or town/country if known)
Children (in age order) a) Full b) Half (<i>please indicate which parent they have in common</i>) c) Adopted d) Twins									
Brothers and Sisters (in age order) a) Full b) Half (<i>please indicate which parent they have in common with you</i>) c) Adopted d) Twins									

Your Mother's Family	Surname, First Name	Male/ Female	Date of Birth or year	Alive Yes/No	Date of Death or year	Cancer Yes/No	Cancer Type <i>(eg. Breast and state which side affected if applicable)</i>	Age at diagnosis or year	Hospital where treated <i>(or town/country if known)</i>
Your Mother									
Your Mother's Sister/s (in age order) a) Full b) Half <i>(please indicate which parent they have in common)</i> c) Adopted d) Twins									
Your Mother's Brother/s (in age order) a) Full b) Half <i>(please indicate which parent they have in common)</i> c) Adopted d) Twins									
Maternal Grandmother (Your Mother's Mother)									
Maternal Grandfather (Your Mother's Father)									

Your Father's Family	Surname, First Name	Male/ Female	Date of Birth or year	Alive Yes/No	Date of Death or year	Cancer Yes/No	Cancer Type <i>(eg. Breast and state which side affected if applicable)</i>	Age at diagnosis or year	Hospital where treated <i>(or town/country if known)</i>
Your Father									
Your Father's Sister/s (in age order) a) Full b) Half <i>(please indicate which parent they have in common)</i> c) Adopted d) Twins									
Your Father's Brother/s (in age order) a) Full b) Half <i>(please indicate which parent they have in common)</i> c) Adopted d) Twins									
Paternal Grandmother (Your Father's Mother)									
Paternal Grandfather (Your Father's Father)									

Other Relatives	Surname, First Name	Male/ Female	Name of parent	Date of Birth or year	Alive Yes/No	Date of Death or year	Cancer Yes/No	Cancer Type <i>(eg. Breast and state which side affected if applicable)</i>	Age at diagnosis or year	Hospital where treated <i>(or town/country if known)</i>
Your Sister/ Children (in age order) a) Full b) Half <i>(please indicate which parent they have in common)</i> c) Adopted d) Twins										
Your Brother/ Children (in age order) a) Full b) Half <i>(please indicate which parent they have in common)</i> c) Adopted d) Twins										
Other Relatives who have had Cancer <i>(eg your cousin)</i> Please make the individual's relationship to yourself as clear as possible <i>(please continue overleaf)</i>										

