

**Family History Questionnaire
Indiana Familial Cancer Clinic
Medical and Molecular Genetics Department
Indiana University School of Medicine**

Instructions

- When filling out the form, please complete both sides
- Please include all biological (blood) relatives whether or not they have been diagnosed with cancer. If you do not have exact dates or ages, please estimate.
- If there is not enough space for all relatives to be listed, please list the additional relatives on a separate sheet of paper and indicate how the individual(s) is related to you.
- You may need to speak with other family members to increase the accuracy of the information on this form. However, we do understand that sometimes information is just not available.
- If you have any questions about completing this form, please contact Cindy Hunter, genetic counselor, at 317-274-3060.
- A return envelope has been included for returning the completed form to us.

Section A: General Information

Name: _____ Maiden Name: _____

Date of Birth: _____

Address: _____

Phone number: _____

Diagnosed with cancer? Yes / No

If yes, type of cancer: _____

Date and/or age diagnosed: _____

Where were you treated? _____

Treatment received: _____

Referring Physician: _____

Address: _____

Section B: Your Parents

Name First and Last	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Your Mother		Yes / No	Yes / No
Your Father		Yes / No	Yes / No

Section C: Your Children

Please list in order of birth

Name First and Last	Name of other parent	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Child #1		M / F		Yes / No	Yes / No
Child #2		M / F		Yes / No	Yes / No
Child #3		M / F		Yes / No	Yes / No
Child #4		M / F		Yes / No	Yes / No

Section D: Your Brothers and Sisters:

Please list in order of birth

Name First and Last	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Sibling #1	M / F		Yes / No	Yes / No
Sibling #2	M / F		Yes / No	Yes / No
Sibling #3	M / F		Yes / No	Yes / No
Sibling #4	M / F		Yes / No	Yes / No
Sibling #5	M / F		Yes / No	Yes / No

Are any of your siblings half-siblings to you, i.e. you share one parent only? Please write their names here and indicate whether you share the same mother or father.

Section E: Your Nieces and Nephews

Sibling's Name (or corresponding number from prior page)	His / Her children Name; Date of birth or Age	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Sibling	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Sibling	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Sibling	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Sibling	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Sibling	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No

Section F: Mother's Family

Mother's Parents

Name First and Last	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Your Mother's Mother		Yes / No	Yes / No
Her maiden name: Her Country of origin/Ethnic background, i.e.: German, Japanese:			
Your Mother's Father		Yes / No	Yes / No
His Country of origin/Ethnic background, i.e.: German, Japanese:			

Mother's Brothers and Sisters (your maternal aunts and uncles)

Name First and Last	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Sibling #1	M / F		Yes / No	Yes / No
Sibling #2	M / F		Yes / No	Yes / No
Sibling #3	M / F		Yes / No	Yes / No
Sibling #4	M / F		Yes / No	Yes / No

Are any of your mother's siblings half-siblings to her, i.e. they share one parent only? Please write their names here and indicate whether they share the same mother or father.

Section G: Maternal First Cousins

Aunt/Uncle's Name	His / Her children (your cousins) Name; Date of birth or Age	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No

Section H: Father's Family

Father's Parents

Name First and Last	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Your Father's Mother		Yes / No	Yes / No
Her maiden name: Her Country of origin/Ethnic background, i.e.: German, Japanese:			
Your Father's Father		Yes / No	Yes / No
His Country of origin/Ethnic background, i.e.: German, Japanese:			

Father's Brothers and Sisters (your paternal aunts and uncles)

Name First and Last	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Sibling #1	M / F		Yes / No	Yes / No
Sibling #2	M / F		Yes / No	Yes / No
Sibling #3	M / F		Yes / No	Yes / No
Sibling #4	M / F		Yes / No	Yes / No

Are any of your father's siblings half-siblings to him, i.e. they share one parent only? Please write their names here and indicate whether they share the same mother or father.

Section I: Paternal First Cousins

Aunt/Uncle's Name	His / Her children (your cousins) Name; Date of birth or Age	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with Cancer? If yes, 1. Type of cancer 2. Age at diagnosis (approximate if uncertain) 3. Treatment
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No
Aunt/Uncle	1. 2. 3.	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No

Section J: Other

Are there other family members diagnosed with cancer that is not listed above?

If so, please write their names here and indicate how they are related to you; please include type of cancer, age at diagnosis and any other details that are available.

Has any family member undergone genetic testing for cancer susceptibility (i.e.: BRCA1, BRCA2, FAP/APC, HNPCC/MLH1 and MSH2)?

If so, please write their name(s) here and indicate the genetic test performed and the result.

Please explain why you are interested in an appointment in this clinic. Are there any specific questions you have?

Thank you for taking the time to complete this form.