The C. R. Wood Cancer Center
Hereditary Cancer & Genetics Program

102 Park Street
Glens Falls, NY 12801
(518) 926-6620
www.glensfallshospital.org

Darci Gaiotti-Grubbs, MD, Director
Rebecca Kerr, MS, CGC
Brooke Roberts, MS CGC

Hereditary Cancer and Genetics Program
Personal and Family History Questionnaire

Dear _____,

We have received a referral requesting an appointment for genetic counseling and cancer risk assessment.

Prior to your appointment, we ask that you take the time to fill out the enclosed questionnaire and to investigate your own medical history and your family history of cancer to the best of your ability. This information will help us to understand who you are and to provide you with the best information. Some questions only pertain to women and some only to men. Please skip questions that are not applicable.

Please complete the enclosed questionnaire and return to us at:

C.R. Wood Cancer Center - Genetics Program
102 Park Street
Glens Falls, NY 12801
Attn: Genetic Counselors

If you have not already received an appointment time, please complete and return this questionnaire. We will contact you to schedule your appointment once the packet is returned.

Please feel free to contact Lois, our patient scheduling specialist at 518-926-6526 with any questions that you may have about our process. Our genetic counselors will review this form with you during your visit and will answer any questions or concerns that you may have.

There is a team of cancer care professionals available to you at the C.R. Wood Cancer Center and we are interested in helping both you and those who are important in your life. Please do not hesitate to ask questions and take advantage of the services available through the Cancer Center.

We are honored that you have chosen us to participate in your care. Thank you!

Sincerely,

The Staff of the C.R. Wood Cancer Center

Hereditary Cancer and Genetics Program
Personal and Family History Questionnaire

Name: _____
(Last) (First) (Maiden)

Birthdate: _____/_____/_____

Preferred contact phone number(s): _____

Is it ok to leave a message on your answering machine? □ Yes □ No

Race: □ White □ Black □ Asian □ Native American

□ Other (please specify): _____

Ethnicity: □ Hispanic □ Non-Hispanic □ Ashkenazi Jewish □ Non-Ashkenazi Jewish

□ Other (please specify): _____

Religion: _____

Are you: □ Married □ Single □ Divorced/Separated □ Widowed/Widower

Who do you live with? □ Alone □ With Spouse

□ Other (please list): _____

Occupation: _____ Place of Employment: _____

Insurance: _____ Name of Insured: _____

Referring Physician: _____ Specialty: _____

Address: _____

Phone Number: _____

Primary Care Physician: _____

Address: _____

Phone Number: _____

To better coordinate your care we would like to send a copy of our consultation note, following your visit, and any genetic tests results that you may have to the above physicians that you have listed.

Do we have your permission to send a copy of your consultation note and genetic test results to the above listed physicians?

Yes_____ No_____

Why are you seeking genetic counseling?

_____

_____

_____

What is your biggest concern?

_____

_____

_____

Personal Cancer History

Have you ever had a cancer diagnosis? ☐ Yes ☐ No

If yes, please complete the following (if more than one diagnosis, please list on back of this page):

Type of cancer:_____

Age at diagnosis:_____

Hospital and city where diagnosed and treated for cancer:_____

_____

Treatment received (e.g., surgery, chemotherapy, tamoxifen, radiation, etc.) :

_____

Previous Medical Tests/Screening

***(Please check those you have had, the most recent date it was performed, and the result.)**

☐ Mammogram Date performed:_____Result:_____

☐ Clinical Breast Exam Date performed:_____Result:_____

☐ GYN Exam Date performed:_____Result:_____

☐ Colonoscopy Date performed:_____Result:_____

☐ Skin Exam Date performed:_____Result:_____

Past Medical History

Have you had:

Thyroid Disease no_____yes_____ Fibrocystic breasts no_____yes_____

Uterine fibroids no_____yes_____ Ovarian cysts no_____yes_____

Basal cell carcinoma no_____yes_____ Colon polyps no_____yes_____

Lipomas/Fibromas no_____yes_____(fatty tumors or skin growths)

Please describe any "yes" answers (where, when treated, etc.) below or on the back of this page.

Social History

Do you currently smoke or have you ever smoked or chewed tobacco? ☐ Yes ☐ No

If yes, how much and for how long? _____

At what age did you start? _____

If you have stopped, at what age did you stop? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, approximately how many drinks per week? ☐ 4 or less ☐ 5-10 ☐ 11-20 ☐ more than 20

Have you had any environmental exposures of concern? (e.g., exposed to harmful chemicals, pesticides, radiation, radon, etc?) ☐ Yes ☐ No If yes, please explain:

_____

If applicable, Past OB/GYN History:

Age at first period:_____ Are your periods regular? ☐ Yes ☐ No

Describe_____

Have you gone through menopause? ☐ Yes ☐ No ☐ Presently occurring

Age at menopause:_____

Have you ever taken hormone replacement therapy? ☐ Yes ☐ No ☐ Uncertain

If yes, age started:_____

If applicable, age stopped (if ever taken):_____

Have you ever used oral contraceptives (birth control pills)? ☐ Yes ☐ No

If yes, total number of years used:_____

Are you currently taking oral contraceptives? ☐ Yes ☐ No

Number of pregnancies_____Number of live births:_____Number of still births:_____

Number of miscarriages and/or abortions:_____

Your age at the birth of your first child:_____

Have you ever had a breast biopsy? ☐ Yes ☐ No If yes, how many and what was the outcome:

_____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No If yes,

outcome_____

Have you had your uterus removed? ☐ Yes ☐ No ☐ Uncertain

If yes, at what age:_____

Have you had your ovaries removed? ☐ Yes ☐ No ☐ Uncertain

If yes at what age:_____

<u>If applicable,</u>

Have you had a vasectomy Yes_____ No_____

If yes, the date of your vasectomy:_____

Have you had a PSA test? Yes_____ No_____

If yes, date of last PSA test_____

Results:_____

For all patients:

Please list your current medical conditions, the treatment and any past illnesses

Medical Condition/Illness	Date	Treatment

Please list past surgical procedures

Procedure and Reason	Date	Hospital Name and Location

Have you, or any member of your family, received genetic testing in the past?

_____

****If yes: please provide a copy of your/family test report for preparation of appointment ****

Any additional personal, social, medical history that you feel is important for us to know in preparation of your appointment:

Family History

Your immediate family (Please list only those related to you through blood. If additional space is needed, please write on back of this page.)
*Please indicate if any of your brothers or sisters are half-siblings and through whom (mom or dad) you are related.

Names	**Current Age**	**Age at death**	**Cause of Death**	**If affected with cancer, list type(s) and treatment (if known)**	**Age at cancer diagnosis**	**Number of children**	**Any children with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis.**
Your Mother							
Your Father							
Your brothers & sisters 1.						#Male #Female	
  2.						#Male #Female	
  3.						#Male #Female	
  4.						#Male #Female	
  5.						#Male #Female	
  6.						#Male #Female	

Your Children

*If you had children with different partners please indicate this next to your child's name. (Please do not include adopted children or step children who are not related to you through blood. If additional space is needed, please write on back of this page.)

Names	**Current Age**	**Age at death**	**Cause of Death**	**If affected with cancer, list type(s) and treatment (if known)**	**Age at cancer diagnosis**	**Number of children**	**Any children with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis.**
Your Children 1.						#Male #Female	
  2.						#Male #Female	
  3.						#Male #Female	
  4.						#Male #Female	
  5.						#Male #Female	
  6.						#Male #Female	
  7.						#Male #Female	
  8.						#Male #Female	

Your Mother's family

Your Mother's family (Please list only those related to you through blood, not through marriage. If additional space is needed, please write on back of this page.)

List the countries/parts of the world your Mother's family is from:_____

List the religious background of your Mother's family:_____

Names	**Current Age**	**Age at death**	**Cause of Death**	**If affected with cancer, list type(s) and treatment (if known)**	**Age at cancer diagnosis**	**Number of children**	**Any children with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis.**
Your Maternal Grandmother (Mother's Mother)							
Your Maternal Grandfather (Mother's Father)							
Your Maternal Aunts/Uncles (Mother's Brothers & Sisters) 1.						#Male #Female	
2.						#Male #Female	
3.						#Male #Female	
4.						#Male #Female	
5.						#Male #Female	
6.						#Male #Female	

Your Father's Family

Your Father's Family (Please list only those related to you through blood, not through marriage. If additional space is needed, please write on back of this page.)

List the countries/parts of the world your Father's family is from:_____

List the religious background of your Father's family:_____

Names	**Current Age**	**Age at death**	**Cause of death**	**If affected with cancer, list type(s) and treatment (if known)**	**Age at cancer diagnosis**	**Number of children**	**Any with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis.**
Your Paternal Grandmother (Father's Mother)							
Your Paternal Grandfather (Father's Father)							
Your Paternal Aunts/Uncles (Father's Brothers & Sisters) 1.						#Male #Female	
2.						#Male #Female	
3.						#Male #Female	
4.						#Male #Female	
5.						#Male #Female	
6.						#Male #Female	

Other family members who have had cancer (e.g., great aunts or great uncles, second cousins, cousins once-removed. If additional space is needed, please write on back of this page.)

List relationship to you and name	**Current Age**	**Age at death**	**Cause of Death**	**If affected with cancer, list type and treatment (if known)**	**Number Of Children**	**Age at cancer diagnosis**	**Any with cancer? If yes, please list name, current age (or age at death), type of cancer, and age at diagnosis.**
1.					#Male #Female		
2.					#Male #Female		
3.					#Male #Female		
4.					#Male #Female		
5.					#Male #Female		
6.					#Male #Female		
7.					#Male #Female		
8.					#Male #Female		
9.					#Male #Female		

The C. R. Wood Cancer Center
At Glens Falls Hospital

Patient Name: _____
Date of Birth: _____
Medical Record: _____

Affix patient ID label here

Authorization for the Release and Use of Protected Health Information

I, the undersigned, being patient/ parent/ legal guardian/ legal representative authorize Glens Falls Hospital (GFH) to use, release and/or disclose the above named individuals health information for the purposes of providing care. In addition, the providers listed below are authorized to release to GFH the information listed below for all dates of service.

Patient information to be released:

X all information relevant to this patient's care
(*) including genetic test result/report (*)

Sensitive Information (check all that apply):
___HIV/AIDS
___ Sexually Transmitted Diseases
___ Drug and Alcohol
___ Behavioral Health

Name of Healthcare Provider	Address

I understand I have the right to revoke this authorization at anytime and that it must be done in writing. I understand that this revocation does not apply to information that has already been released. I understand that this revocation does not apply to requests from Government Agencies, Insurance Companies and certain Law Enforcement Officials, etc., who are entitled to the information without authorization under HIPAA, Federal Regulations and State Regulations. This authorization will expire within one year of signing.

I understand that I may review the information and/or retain a copy of the information to be disclosed (refer: 45CFR 164.524). I understand that any disclosure of information has the potential for unauthorized re-disclosure and that I may not be protected by Federal and State Privacy/Confidentiality Regulations. I understand that if I should have any questions I can contact the Director, CR Wood Cancer Center. I understand that under certain circumstances, I may be required to produce supporting legal documentation in cases of Custody, Proxy, Foster Children, Executor of the Estate, etc.

_____ _____ _____ _____
Signature of Patient, Parent, Legal Guardian Date Relationship to Patient Date

_____ _____
Signature of Emancipated Minor Date
(as appropriate – Court Documentation required)

Notice to recipient: This information has been disclosed to you from medical records whose confidentiality is protected by Federal and State Regulations. These regulations prohibit you from re-disclosure without the written consent of the patient / parent / legal guardian or otherwise permitted by specific regulations. Anyone who receives this information covered by these regulations obtained legally or not, is prohibited by law from using the information for any criminal or civil investigation (42 CFR Part 2, 45 CFR 164, NYS Title E-Article 13, NYS Title 10 Chapter V Article 2 Part 405).