



Hereditary Cancer Risk Program

Family History and Risk Assessment Questionnaire

Please answer questions to the best of your ability in order to help us establish your risk assessment. Write in "unk" (unknown) for information not known.

If you have any questions or if you need to schedule/change an appointment, please call
214-820-9600

Please send or fax this completed questionnaire (page 2-7) to us at least 1 week prior to your appointment
(Fax: 214-820-9606)

Your Breast History - all participants, including Males	
Do you have or did you have a history of breast problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:
Have you ever had a breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many have you had? #___
Result of <u>last</u> biopsy	<input type="checkbox"/> Atypical hyperplasia <input type="checkbox"/> In-situ (DCIS or LCIS) <input type="checkbox"/> Invasive (lobular or ductal carcinoma) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown
If you have ever been diagnosed with cancer, please complete the following section	
Breast Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Which Breast? <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Age at diagnosis: _____	<input type="checkbox"/> Lumpectomy- Left___ Right___ age _____ <input type="checkbox"/> Mastectomy- Left___ Right___ age _____ Surgeon: _____ <input type="checkbox"/> Radiation therapy Radiation Oncologist: _____ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other treatment: _____ Oncologist: _____
Other Cancer: _____ Type Age at diagnosis: _____	<input type="checkbox"/> Surgery: _____ <input type="checkbox"/> Other treatment: Physician: _____
Other Cancer: _____ Type Age at diagnosis: _____	<input type="checkbox"/> Surgery: _____ <input type="checkbox"/> Other treatment: Physician: _____

Family Tree

	Total (Indicate half siblings)	Ages		Total (Indicate half siblings)	Ages
How many sisters do you have?			How many brothers do you have?		
How many daughters do you have?			How many sons do you have?		
How many maternal aunts do you have?			How many maternal uncles do you have?		
How many paternal aunts do you have?			How many paternal uncles do you have?		

Personal Risk Assessment

Your background - All Participants	
<p>What is your race or ethnic background? <i>(this can indicate certain risks)</i> If you are multi-racial, check all that apply</p>	<p> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> E. Indian <input type="checkbox"/> French Canadian <input type="checkbox"/> Mediterranean/Greek/Italian <input type="checkbox"/> Native American Indian <input type="checkbox"/> Multiracial <input type="checkbox"/> Other: _____ <input type="checkbox"/> Ashkenazi Jewish descent What country is your mother's family from? _____ What country is your father's family from? _____ <input type="checkbox"/> Adopted </p>
<p>What is the highest level of education you completed?</p>	<p> <input type="checkbox"/> Elementary School <input type="checkbox"/> Middle School <input type="checkbox"/> High School <input type="checkbox"/> Some College <input type="checkbox"/> College Degree <input type="checkbox"/> Graduate Degree <input type="checkbox"/> Professional School </p>
<p>What is your Occupation?</p>	

Your Lifestyle History - <u>All Participants</u>	
Tobacco Use	<p>Do you smoke?</p> <p><input type="checkbox"/> Yes For how many years? _____</p> <p><input type="checkbox"/> Used to smoke, but have quit How many years did you smoke? _____</p> <p><input type="checkbox"/> No</p> <p>Do you use other types of tobacco?</p> <p><input type="checkbox"/> Yes What kind? _____</p> <p><input type="checkbox"/> No</p>
Do you ever drink alcoholic beverages?	<p><input type="checkbox"/> Yes How many beverages per week? _____</p> <p><input type="checkbox"/> No</p>
Do you exercise regularly?	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Do you have any ongoing health problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Briefly describe any health problems here:</p>
Do you have any questions or concerns for the genetic counselor?	