FOR OFFICE USE
Date of appt: ______________________
MR #: ______________________
Indication: ______________________
Referred by: ______________________

Genetic Counseling Questionnaire

Name: ____

Address: ____

____

Telephone # Preferred: ____________________ Additional telephone #:__________________

May we leave a message and on which number(s)? ______________________________

May we e-mail regarding your care? List e-mail if yes: _____________________________

Insurance type: ____

Occupation: ____________________________ Marital Status:_____________________

Religion: ___________ Do you practice your religion? _____________________________

Main source of emotional support: ____

Date of Birth: ___________________________ Age:_____________________________

What countries are your mother's ancestors from? ______________________________

Your father's? ____

Do you have any questions or concerns regarding this visit?

____

____

Before this appointment, had you ever been offered genetic counseling? ☐ No ☐ Yes

Before this appointment, had you ever been offered genetic testing? ☐ No ☐ Yes For what?

____

Medical History:

Height: __________ Weight: __________
Do you have any chronic illnesses or gastrointestinal conditions? Please list:

____

____

Have you had any past surgeries, major radiation, or hospitalizations? If yes, please list date and reason:

____

____

____

____

Please continue to the next page

Patient Name: ___________________________________ **DOB:** _________

Do you take any medications? ☐ No ☐ Yes Please list names and reason for taking:

____

____

____

Do you have a history of benign growths, such as lipomas or fibroids, or dermatological findings, such as trichilemmomas, keratoses, or oral papules? If yes, please describe and bring records:

____

Have you had a history of any of the following, check all that apply:

☐ Hypertension ☐ Headaches ☐ Excessive sweating ☐ Palpitations ☐ Fever
☐ Hyperglycemia ☐ Nervousness ☐ Nausea ☐ Vomiting ☐ Chest/abdominal pain
☐ Fatigue ☐ Heat intolerance ☐ Other sensory disturbances ☐ Thyroid abnormalities

Do you smoke or use tobacco products? Currently? ☐ No ☐ Yes Previously? ☐ No ☐ Yes
If yes, what do you use and how much? ____

Do you drink alcohol beverages? ☐ No ☐ Yes Average/week? ____________________
Have you had any environmental exposures of concern? ☐ No ☐ Yes Please explain:

____

Reproductive History (Women Only):

Age at first menstruation: ________________ Age at first delivery: ________________________

How many pregnancies have you had? ______ How many living children? _________________

Have you ever used oral contraceptives? ☐ No ☐ Yes # of years? _________________

Have you gone through menopause yet? ☐ No ☐ Yes If yes, at what age? ___________

If yes, was it: ☐ Naturally occurring ☐ Surgically induced ☐ Chemically induced

Have you taken hormone replacement therapy? ☐ No ☐ Uncertain ☐ Yes # of years? ____

Have you had any other hormone treatment, e.g. infertility or thyroid? ☐ No ☐ Yes

Age started: ______ # Years: ______ Reason: ____

Cancer Screening Practices:

Please complete the following information if you have had these screening tests previously

*****Pathology reports are very important for any biopsy done.**
All colonoscopy and/or endoscopy reports are requested as well.***

Screening Tests	Most Recent	How Often	Age Started	Result/Biopsy done?
Colon:				
Colonoscopy	___________	___________	___________	_________________
Sigmoidoscopy	___________	___________	___________	_________________
FOBT:	___________	___________	___________	_________________

Please continue to the next page

Patient Name: ___________________________________ **DOB: ___ ______**

Upper GI:				
Endoscopy	___________	___________	___________	________________
Endometrial (women only):				
Sampling/biopsy	___________	___________	___________	________________
Ovarian (women only):				
Pelvic exam	___________	___________	___________	________________
Ultrasound	___________	___________	___________	________________
CA 125 blood test	___________	___________	___________	________________
Cervical (women only):				
PAP Smear/pelvic	___________	___________	___________	________________
Breast (women only):				
Self-breast exam	___________	___________	___________	________________
Clinical breast exam	___________	___________	___________	________________
Mammogram	___________	___________	___________	________________
Ultrasound	___________	___________	___________	________________
MRI	___________	___________	___________	________________
Prostate (men only):				
Digital rectal exam	___________	___________	___________	________________
PSA	___________	___________	___________	________________
Skin:				
Full body derm. exam	___________	___________	___________	________________
Other	___________	___________	___________	________________
	___________	___________	___________	________________
	___________	___________	___________	________________

Biopsy history

Preferably, bring any pathology reports for any biopsies performed. If not Please use this space to describe any biopsy results, especially if no report is available. For example, describe number of polyps and polyp type found with colonoscopy.

Type (e.g. colon)	Date	Pathology finding	Recommended follow-up
________________	__________	______________________	______________________
________________	__________	______________________	______________________
________________	__________	______________________	______________________
________________	__________	______________________	______________________
________________	__________	______________________	______________________

Patient Name: ___________________________________ **DOB:** _________

Personal history of cancer (If no history, continue to next page):

*****Please bring any pathology reports and/or relevant medical records.*****

	First primary cancer	Second primary cancer
What led to diagnosis? (ex. Routine screening, felt lump, pain, etc.)		
Age at diagnosis		
Site of tumor (ex. colon)		
Tumor size		
Tumor stage		
Where diagnosed		
Surgery (Yes or no, where?)	Yes No	Yes No
Chemotherapy (Y/N, where?)	Yes No	Yes No
Radiation (Y/N, where?)	Yes No	Yes No
Recurrence (Y/N and date)	Yes No	Yes No

BREAST CANCER

If you were diagnosed with breast cancer, was the tumor (check one on each line):

☐ Estrogen receptor positive **OR** ☐ Estrogen receptor negative
☐ Progesterone receptor positive **OR** ☐ Progesterone receptor negative
☐ Her2neu receptor positive **OR** ☐ Her2neu receptor negative

If you were a candidate for tamoxifen, did you take it? ☐ No ☐ Yes Dates of use __________

COLORECTAL AND ENDOMETRIAL (UTERINE) CANCER

If you were diagnosed with colorectal or endometrial cancer, was microsatellite instability (MSI) testing performed on the tumor? (Check one)

☐ YES ☐ NO ☐ I DON'T KNOW **If YES, check the result:**
☐ MSI-high **OR** ☐ MSI-low **OR** ☐ MSI-stable

If you were diagnosed with colorectal or endometrial cancer, was immunohistocompatibility (IHC) testing performed on the tumor? (Check one)

☐ YES ☐ NO ☐ I DON'T KNOW If yes, what was the result?
(e.g. MLH1/MSH2/MSH6/PMS2 all expressed OR one protein missing)

____

Please continue to the next page

Patient Name: ___________________________________ **DOB:** _________

Cancer Family History

Please complete about family members on BOTH your mother's and father's sides, including children, siblings, parents, aunts, uncles, grandparents, and cousins, who have a previous or current cancer diagnosis. We also need to know age/age at death and cause of death for all other relatives, including great grandparents, grandparents, aunts, uncles, and cousins.

*****If genetic testing, pathology reports, or other records describing cancer diagnosis are available, please send or bring them.*****

First Name	Relationship to you: (Aunt on father's side, maternal grandmother)	Cancer type and stage	Age at diagnosis	If living, current age:	If deceased, age at death	Has this relative ever had genetic counseling OR testing?	Are medical records for this relative available to you?
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes
						No Yes	No Yes