Western Australia
Oncology
Menopause
Endometriosis
New Mothers

P + 61 8 **9468 5188**
F + 61 8 **9381 2006**

Suite 20, 2 McCourt Street,
West Leederville, WA 6007

genetics@womencentre.com.au

www.womencentre.com.au

Family History Questionnaire for Genetic Counselling

Please complete the following questionnaire and return to WOMEN Centre by email/fax/post **prior to your genetic counselling appointment**.

SECTION 1 : BACKGROUND

FIRST NAME _____ ◯ MR ◯ MRS ◯ MS ◯ MISS ◯ OTHER

SURNAME _____

MAIDEN NAME_____ DOB _____ /_____ /_____

ADDRESS _____

SUBURB _____ STATE _____ POST CODE _____

HOME PHONE _____ WORK PHONE _____ MOBILE _____

OCCUPATION _____ EMAIL ADDRESS _____

NAME OF YOUR GP _____

ADDRESS OF YOUR GP _____

HAS ANYONE IN YOUR FAMILY EVER HAD GENETIC COUNSELLING ? ◯ NO (go to SECTION 2) ◯ YES (continue below)

RELATIVES WHO HAVE HAD GENETIC COUNSELLING				
NAME	DOB	RELATIONSHIP TO YOU	WHERE WERE THEY SEEN	DID THEY HAVE GENETIC TESTING
				◯ YES ◯ NO ◯ UNSURE
				◯ YES ◯ NO ◯ UNSURE

SECTION 2 : PERSONAL HISTORY

HAVE YOU EVER HAD CANCER ? ◯ NO (go to next page) ◯ YES (continue below)

PERSONAL HISTORY OF CANCER				
DIAGNOSIS	DATE OF DIAGNOSIS	SPECIALIST	WHERE WERE YOU SEEN	PATHOLOGY REPORT ATTACHED (If you have access to a copy)
				◯ YES ◯ NO
				◯ YES ◯ NO
				◯ YES ◯ NO

HAVE YOU EVER HAD ANY CANCER SURVEILLANCE (EG MAMMOGRAM, COLONOSCOPY, GASTROSCOPY) ?

◯ NO (go to SECTION 3) ◯ YES (continue below)

PERSONAL HISTORY OF CANCER SURVEILLANCE				
PROCEDURE	DATE OF PROCEDURE	SPECIALIST	OUTCOME OF PROCEDURE	PATHOLOGY REPORT ATTACHED (If you have access to a copy)
				◯ YES ◯ NO
				◯ YES ◯ NO

SECTION 3 : FAMILY HISTORY

YOUR PARENTS					
NAME	DATE OF BIRTH / DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
MOTHER					◯ YES ◯ NO
FATHER					◯ YES ◯ NO

YOUR CHILDREN (WITH OR WITHOUT CANCER)						
NAME	GENDER	DATE OF BIRTH / DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
CHILD 1	◯ M ◯ F					◯ YES ◯ NO
CHILD 2	◯ M ◯ F					◯ YES ◯ NO
CHILD 3	◯ M ◯ F					◯ YES ◯ NO
CHILD 4	◯ M ◯ F					◯ YES ◯ NO
CHILD 5	◯ M ◯ F					◯ YES ◯ NO
CHILD 6	◯ M ◯ F					◯ YES ◯ NO

YOUR BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)

NAME OF SIBLING (A) HALF SIBLING – SAME MOTHER (B) HALF SIBLING – SAME FATHER	GENDER	DATE OF BIRTH DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
SIBLING 1 ○A ○B	○ M ○ F					○ YES ○ NO
SIBLING 2 ○A ○B	○ M ○ F					○ YES ○ NO
SIBLING 3 ○A ○B	○ M ○ F					○ YES ○ NO
SIBLING 4 ○A ○B	○ M ○ F					○ YES ○ NO
SIBLING 5 ○A ○B	○ M ○ F					○ YES ○ NO
SIBLING 6 ○A ○B	○ M ○ F					○ YES ○ NO

YOUR NIECES AND NEPHEWS (WITH OR WITHOUT CANCER)

NAME OF NIECE/NEPHEW NAME OF YOUR SIBLING WHO IS THE NIECE/ NEPHEW'S PARENT	GENDER	DATE OF BIRTH DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
NIECE/NEPHEW 1 SIBLING	○ M ○ F					○ YES ○ NO
NIECE/NEPHEW 2 SIBLING	○ M ○ F					○ YES ○ NO
NIECE/NEPHEW 3 SIBLING	○ M ○ F					○ YES ○ NO
NIECE/NEPHEW 4 SIBLING	○ M ○ F					○ YES ○ NO
NIECE/NEPHEW 5 SIBLING	○ M ○ F					○ YES ○ NO

YOUR GRANDPARENTS					
NAME	DATE OF BIRTH DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
MATERNAL GRANDMOTHER					◯ YES ◯ NO
MATERNAL GRANDFATHER					◯ YES ◯ NO
PATERNAL GRANDMOTHER					◯ YES ◯ NO
PATERNAL GRANDFATHER					◯ YES ◯ NO

YOUR MOTHER'S BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)						
NAME	GENDER	DATE OF BIRTH DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
AUNT / UNCLE 1	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 2	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 3	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 4	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 5	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 6	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 7	◯ M ◯ F					◯ YES ◯ NO
AUNT / UNCLE 8	◯ M ◯ F					◯ YES ◯ NO

YOUR FATHER'S BROTHERS AND SISTERS (WITH OR WITHOUT CANCER)

NAME	GENDER	DATE OF BIRTH / DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
AUNT / UNCLE 1	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 2	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 3	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 4	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 5	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 6	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 7	○ M ○ F					○ YES ○ NO
AUNT / UNCLE 8	○ M ○ F					○ YES ○ NO

ANY OTHER BLOOD RELATIVE WITH CANCER

NAME AND RELATIONSHIP TO YOU (eg first cousin) (M) - Maternal (P) - Paternal Relative	GENDER	DATE OF BIRTH / DATE OF DEATH (IF APPLICABLE)	TYPE(S) OF CANCER (i.e. where cancer started)	AGE AT DIAGNOSIS	OTHER HISTORY (number of colon polyps, uterine fibroids, other benign tumors, thyroid disease,etc.)	PATHOLOGY REPORT AND/OR DEATH CERTIFICATE ATTACHED (If you have access to a copy)
○M ○P	○ M ○ F					○ YES ○ NO
○M ○P	○ M ○ F					○ YES ○ NO
○M ○P	○ M ○ F					○ YES ○ NO
○M ○P	○ M ○ F					○ YES ○ NO

SECTION 4 : ADDITIONAL INFORMATION

ARE THERE ANY SIGNIFICANT HEALTH CONDITIONS OTHER THAN CANCER THAT HAVE AFFECTED YOUR FAMILY ?

IS THERE ANY OTHER INFORMATION THAT COULD FACILITATE YOUR GENETIC COUNSELLING ?

1. Please note that the information supplied is confidential and patient privacy is always maintained.
2. I declare that all information written on the above form is true to the best of my knowledge.
3. Medical students may be present during consultations, if you do not wish this, please inform your genetic counsellor.
4. I consent for my medical information to be forwarded to other health professionals if necessary.

Sign _____Date _____/_____/_____

Submit