

## Family History Questionnaire

This questionnaire will gather information about the history of cancer in your family. This information will be used by the University of Michigan Cancer Genetics Clinic to help determine your risk of developing cancer and to decide if the cancers in your family may be related to an inherited gene. This information will not be used to contact your family members. Family members' initials are used to help maintain their confidentiality and to help reduce errors as we build your family tree. You may refuse to answer any (or all) of the questions at this time or any other time. When you return the questionnaire, you are agreeing that your family history information will be entered into a confidential computerized database.

### WHAT YOU NEED TO FIND OUT

Specifically, you need to try to find out the following information about your relatives with cancer:

- Relationship to you (e.g. mother's father's sister)
- Specific type of cancer (e.g. breast, colon, ovarian, etc.)
- Unilateral or bilateral (e.g. left breast or both breasts)
- Second cancers – for relatives who developed a second cancer, did the second cancer result from spreading of the first cancer or was it considered a separate new cancer.
- Environmental exposures (e.g. smoking, radiation, asbestos)
- Age at diagnosis
- Current age or age and cause of death

### INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

- Information should be provided on biological relatives only  
Do not provide information about adopted, foster or step-relatives.
- Indicate half-brothers and half-sisters with an asterisk (\*) by their initials  
Indicate maternal half-brothers and half-sisters (same mother, different father) with \*M  
Indicate paternal half-brothers and half-sisters (same father, different mother) with \*P
- If exact age is not known, approximate: (e.g. early 40's, late 60's)
- If requested information is not known, write "unknown."
- If additional space is needed, please attach another sheet of paper and indicate which question is being addressed.

The questionnaire can be returned to:

Cancer Genetics Clinic  
The University of Michigan  
Division of Molecular Medicine and Genetics  
300 North Ingalls  
Ann Arbor, MI 48109-0419

FAX: 734-763-7672

Name:	Date:	Appointment Date:
Occupation:	Date of Birth:	

**Your Physician:**

**Referring Physician (if different):**

Name:	Name:
Address:	Address:
Phone:	Phone:

Did this physician refer you to our clinic? Yes No

Are you adopted? Yes No

If YES, do you know family/medical history information about either of your biological parents?

Yes No

If YES, please complete the family history form with this information

If NO, do not complete the form.

Are any of your relatives adopted? Yes No

If YES, indicate name(s) and relationship to you: \_\_\_\_\_

Indicate whether you or any of your relatives have a family history of any of the following\*:

**(Circle Y-Yes; N-No)**

- |   |   |
|---|---|
| 1. Y N Birth defects (e.g. cleft lip, club foot)  | 16. Y N Muscle disease  |
| 2. Y N Bleeding disorders (e.g. Hemophilia)   | 17. Y N Neurofibromatosis   |
| 3. Y N Blindness/Eye abnormality  | 18. Y N Neurologic disorder   |
| 4. Y N Connective tissue disorder (e.g. Marfan syndrome, Ehlers-Danlos syndrome, Osteogenesis Imperfecta) | 19. Y N Psychiatric disorder (e.g. schizophrenia, manic-depression) |
| 5. Y N Deafness   | 20. Y N Respiratory disorder/cystic fibrosis                        |
| 6. Y N Diabetes   | 21. Y N Seizures/Epilepsy   |
| 7. Y N Down syndrome  | 22. Y N Severe anemia/sickle cell anemia/thalassemia                |
| 8. Y N Early onset (<65 years old) Alzheimer's  | 23. Y N Skeletal disorders/short stature                            |
| 9. Y N Early onset (<50 years old) Cancer   | 24. Y N Skin disorder   |
| 10. Y N Early onset (<50 years old) Emphysema   | 25. Y N Spina bifida/hydrocephaly                                   |
| 11. Y N Early onset (<50 years old) Heart disease   | 26. Y N Stillbirths/children who died young                         |
| 12. Y N Fragile X syndrome  | 27. Y N Pregnancy losses (individual w/more than 2)                 |
| 13. Y N Kidney disease  | 28. Y N Chromosome abnormality, other                               |
| 14. Y N Mental retardation  | 29. Y N Other inherited/genetic condition(s)                        |
| 15. Y N Metabolic disorders (e.g. PKU, Tay-Sachs)   |   |

\*If you circled “**YES**” to any of the above conditions, be sure to list the condition(s) in the “Significant Medical Conditions” column when completing the following pages about your relatives.

Have any of your relatives had genetic testing? Yes No

If yes, please provide as much of the following information as possible:

Name	Relationship To you	Condition tested for	Laboratory	Result

**YOUR CHILDREN**

Name of your children	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Current age or Birthdate (if known)	Age at Death (Date if known)	Cancer diagnosis	Age at Diagnosis	Other medical conditions (please include colon polyps, precancerous skin moles, breast biopsies)
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					
	M F	L D					

**Your Full Brothers and Sisters  
(share both a mother and father)**

Name of your brother's and sisters: First (Maiden) Last	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Current age or Birthdate (if known)	Age at Death (Date if known)	Cancer diagnosis	Age at Diagnosis	Other medical conditions	Your brothers' and sisters' children
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D						#sons _____ ages: _____ #daughters _____ ages: _____

	M F	L D							#sons _____ ages: _____ #daughters _____ ages: _____
	M F	L D							#sons _____ ages: _____ #daughters _____ ages: _____

### HALF BROTHERS AND SISTERS

Please list your half brothers and sisters with whom you share only one parent. If you do not have any half brothers or sisters, check here: \_\_\_\_\_.

Name of your brother's and sisters First (Maiden) Last	M-Male F-Female (circle)	L-Living D- Deceased (circle)	Current Age or Birthdate (If known)	Age at Death (Date if known)	Shared parent (please circle)	Cancer Diagnosis	Age at diagnosis	Other medical conditions	Your Brothers' and Sisters' children
	M F	L D			Mother Father				# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D			Mother Father				# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D			Mother Father				# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D			Mother Father				# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D			Mother Father				# sons _____ ages: _____ # daughters _____ ages: _____

## YOUR MOTHER'S FAMILY

Your mother's family's countries of origin (i.e. Irish, Chinese, English): \_\_\_\_\_ Are you Jewish? \_\_\_ YES \_\_\_ NO

Have related family members (e.g. first cousins) married each other? \_\_\_ YES \_\_\_ NO

If YES, provide names and their relationship to each other: \_\_\_\_\_

	Name First (Maiden) Last	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Current Age Or Birthdate (If known)	Age at Death (Date if known)	Cancer Diagnosis	Age at DX	Other medical conditions (please include history of colon polyps, pre-cancer skin moles, breast biopsies)	<b>Aunts and Uncles' Children</b>
Your Mother		M F	L D						
Your Mother's <b>Father</b>		M F	L D						
Your Mother's <b>Mother</b>		M F	L D						
Your Mother's Brothers and Sisters <b>If your mother has no brothers or sisters, check here</b> _____.		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____

	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____

## YOUR FATHER'S FAMILY

Your father's family's countries of origin (i.e. Irish, Chinese, English): \_\_\_\_\_ Are you Jewish?  YES  NO

Have related family members (e.g. first cousins) married each other?  YES  NO

If YES, provide names and their relationship to each other: \_\_\_\_\_

	Name First (Maiden) Last	M-Male F-Female (circle)	L-Living D- Deceased (circle)	Current Age Birthdate (If known)	Age at Death (Date if known)	Cancer Diagnosis	Age at DX	Other medical conditions (please include history of colon polyps, pre- cancer skin moles, breast biopsies)	Your Aunts and Uncles' Children
Your Father		M F	L D						
Your Father's <b>Father</b>		M F	L D						
Your Father's <b>Mother</b>		M F	L D						
Your Father's Brothers and Sisters <b>Check here if your father has no brothers or sisters</b>		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
		M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____

	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____
	M F	L D						# sons _____ ages: _____ # daughters _____ ages: _____

If you have children, complete this information on their other parent (your wife/husband/partner). Duplicate this page if your children have different parents.

Name of your children's other parent: \_\_\_\_\_ Birthdate/Age: \_\_\_\_\_

Does this parent have a family history of cancer? \_\_\_\_YES \_\_\_\_ NO

**If this parent has had a family history of cancer, please list affected relatives. If this parent has had cancer, please write "parent" in the "relationship" column.**

Name First (Maiden) Last	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Current Age Birthdate (If known)	Age at Death or Date of death if known	Relationship To your child's other parent	Cancer diagnosis	Age at Diagnosis	Other medical conditions
	M F	L D						
	M F	L D						
	M F	L D						
	M F	L D						
	M F	L D						

Does this parent have a family history of birth defects/mental retardation/genetic disorders/pregnancy losses? \_\_\_\_ YES \_\_\_\_ NO

Please describe: \_\_\_\_\_

**Other Relatives with Cancer**

Please use this area to include information regarding any other family members diagnosed with cancer

Name First (Maiden) Last	M-Male F-Female (circle)	L-Living D- Deceased (circle)	Current Age or Birthdate (If known)	Age at Death (Date if known)	Relationship (e.g. mother's sister, father's brother's son)	Cancer Diagnosis	Age at Diagnosis	Other medical conditions (please include history of colon polyps, precancer skin moles, breast biopsies)
	M F	L D						
	M F	L D						
	M F	L D						
	M F	L D						
	M F	L D						