Pediatric Oncology Genetics Clinic Family History Form

Molecular and Medical Genetics
Oregon Health & Science University (OHSU), Doernbecher Children's Hospital

Attach patient label here

This form will help us understand your family history and prepare for your Genetics visit. We appreciate your time!

1) You may need to speak with other relatives to increase the accuracy of the information on this questionnaire. We understand that sometimes information is just not available to you. However, the more information you are able to provide, the more accurate our assessment.
2) If you have any questions about completing the questionnaire, please contact medical genetics scheduling at 503-494-8307. Please return the questionnaire by email: MMGPASR@ohsu.edu or FAX: 503-346-8268 Attn: Peds Onc Genetic Counselor

Brothers and sisters of patient

First Name	Sex M/F	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	Mother's First Name	Father's First Name
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				

If there are any health problems with the brothers' and sisters' children (patient's nieces and nephews), please note.

_____
_____
_____
_____

Mother's Family History

Mother's First Name	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	# Children Male	Female
	□Yes, current age: _____ □No, age at death: _____ Cause of death:				

Mother's brothers and sisters (maternal uncles and aunts of the patient)

First Name	Sex M/F	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	Mother's First Name	Father's First Name	# Children* Male	Female
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						

*If there are any health problems with the mother's brothers' and sisters' children (patient's cousins), please note.

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Mother's parents (maternal grandparents of the patient)

First Name	Sex M/F	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	# Children Male	Female
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				

Father's Family History

Father's First Name	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	# Children Male	Female
	□Yes, current age: _____ □No, age at death: _____ Cause of death:				

Father's brothers and sisters (paternal uncles and aunts of the patient)

First Name	Sex M/F	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	Mother's First Name	Father's First Name	# Children* Male	Female
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						
		□Yes, current age: _____ □No, age at death: _____ Cause of death:						

*If there are any health problems with the father's brothers' and sisters' children (patient's cousins), please note.

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Father's parents (paternal grandparents of the patient)

First Name	Sex M/F	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	# Children Male	Female
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				

Children of patient (skip if the patient does not have any children)

First Name	Sex M/F	Living?	Affected with Cancer? Y/N	Type of cancer and age at diagnosis (if applicable)	Mother's First Name	Father's First Name
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				
		□Yes, current age: _____ □No, age at death: _____ Cause of death:				

Has the patient been diagnosed with cancer?□yes □no If yes, which type(s) and age at diagnosis?_____
Treatment(s) included? (Check all that apply)□surgery □chemotherapy□radiation□other_____

Has the patient had any of the following?

	Yes	No	Findings/Results
Birth Defect	☐	☐	
Head Imaging	☐	☐	
Abdominal Imaging	☐	☐	
Other Imaging	☐	☐	
Sigmoidoscopy, Colonoscopy, Upper Endoscopy	☐	☐	
Genetic Testing	☐	☐	

Has anyone in the patient's family had genetic testing?□yes□no If yes, which relative(s)? _____
Results_____*Please attach a copy of the genetic test result if possible*

Please feel free to write in any additional comments or information you feel is important for us to know:

_____
_____
_____
_____
_____

Thank you for taking the time to complete this questionnaire. The information will help us prepare for your visit.