What are your main questions which you would like to discuss with the Cancer Genetics Team?

____

____

____

Please complete this section if you are receiving any cancer surveillance (screening)

- Mammography? Yes ☐ No ☐ If yes, how often____________, date of last one_________
- MRI breast? Yes ☐ No ☐ If yes, how often____________, date of last one_________
- Colonoscopy? Yes ☐ No ☐ If yes, how often____________, date of last one_________
- Other? Please state type:
  ______________ Yes ☐ No ☐ If yes, how often____________, date of last one_________

Have you or any other members of your family attended a genetics department before? If yes:

- Name ______________________________
- Date of birth ______________________________
- Where seen ______________________________
- When (date) ______________________________
- Relationship to you ______________________________
- Family reference number, if known ______________________________

Have you or any other members of your family ever had a genetic test? If yes:
Please give test details ____

Some types of genetic cancer are slightly more common in certain ethnic groups or those of Jewish ancestry:

- Are you, your partner or any of your immediate family Jewish? Yes ☐ No ☐
- Are you, your partner or any of your immediate family Polish? Yes ☐ No ☐
- Please state your ethnic origin __________________________
- Are you and your partner blood related, for example, cousins? Yes ☐ No ☐

Thank you for completing this questionnaire. Please return it to the above named address.

If another copy is required please log on to our website **www.genetics.ie/clinical** to download another copy.

Once we have reviewed this Family History Questionnaire one of the following may occur:

- We may write to you with screening advice but not offer an appointment
- We may advise that your relative with cancer is seen by genetic services
- We may offer you a telephone appointment
- We may offer you a face to face appointment at one of our clinics

Department of Clinical Genetics

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Dublin 12
Tel.: (01) 409 6722
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PRIVATE AND CONFIDENTIAL

Family History Questionnaire

You have been referred to the Cancer Genetic Service because of a history of cancer in you and/or your family. Please complete this questionnaire which will help us to assess whether or not your family history places you at an increased risk of cancer and whether increased surveillance and/or genetic testing would be recommended. Please **return this questionnaire within the next 2 weeks**.

Please attempt to complete as many sections as possible. The more details you can provide, the more accurate we can be in our assessment. It is important to include those family members (alive and deceased) **who have had**, as well as those **who have not had** cancer, as this will have a bearing on your overall cancer risk. **If any member of your family has attended genetic services here or elsewhere please give their details. Please also let us know details of any family member already on our waiting list.** (Use additional paper, if required, for further relevant information)

Please complete all four pages and return the questionnaire within 2 weeks. We will not be able to offer an assessment of your cancer risk, or process your referral, until we have received your completed questionnaire.

If you have any queries or difficulties in completing the questionnaire, please do not hesitate to contact us at the above number. If you are unable to complete all the sections, please return the form anyway.
Thank you

Name ____________	GP Name ____________
Date of birth ____________	GP Address ____________
Address ____________	____________
____________	____________
Postcode ____________	____________
Landline ____________	Telephone No ____________
Mobile ____________	
Email ____________	☐ Please indicate here if you are **NOT** on the telephone

For office use only:

Date FHQ received in Department

Family Ref number PED:

Please complete the form below, giving as much information as possible about your immediate (blood) relatives, **including those who have NOT had cancer**

If there is any information you do not know, perhaps someone in your family will be able to help you, otherwise leave that box empty. You may find it easier to start on the row that refers to your mother and complete all boxes relating to her before you start on the next member of your family. All the information you give will be held in confidence in the Department of Clinical Genetics.

THE INDIVIDUALS OUTLINED BELOW WILL NOT BE CONTACTED DIRECTLY, BUT WE MAY USE THE INFORMATION PROVIDED TO VALIDATE THEIR DIAGNOSIS.

Please continue onto additional sheets of paper if necessary.

Relative	Name (including maiden and any previous names) and Last known address	D.O.B.	Is the person still alive Yes/No	If they are dead what was their date of death	Type of cancer(s) in you or your relative..... Which part of the body was affected by cancer	Age when cancer found	Hospitals where treated Please also give the name of specialist if known
Self							
Your own children							
Your sisters (full or half)							
Your brothers (full or half)							
Your mother							
Your father							
Your mother's mother							
Your mother's father							
Your father's mother							
Your father's father							
Your father's brothers and sisters							
Your mother's brothers and sisters							

If any other relatives have had cancer (cousins etc), please include details on a separate sheet of paper stating clearly whether they are related to you through your mother or your father