Cancer Risk Evaluation Program
HEALTH & FAMILY HISTORY QUESTIONNAIRE

IF YOU HAVE ANY QUESTIONS ABOUT COMPLETING THIS FORM, PLEASE CALL 732-557-2154.

Your Name: _____
First *Last* *(Maiden / Former)*

Current Address: _____
Street *Apt. #* *City* *State*

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred Contact: ☐ Home ☐ Work ☐ Cell ☐ Other:_____ Best Time to Reach You: _____

May we leave a message? ☐ Yes, detailed ☐ Yes, limited (name, hospital, call back number only) ☐ No

Date of Birth _____ Current Age _____ Current Height: _____ Current Weight: _____

Current Marital Status: ☐ Married or Living as Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Never Married ☐ Domestic Partnership ☐ Other _____

Your Occupation (or former occupation, if no longer working): _____

Highest level of school you have completed: ☐ 8th grade or less ☐ Some high school ☐ High school grad/GED

☐ Some college or technical school ☐ Graduated college ☐ Graduate or professional school Other ☐ _____

Race/Ethnicity How would you describe your primary **racial background**? *Please check the appropriate boxes below*.

☐ Caucasian
☐ African American
☐ Hispanic
☐ American Indian or Alaskan Native
☐ Asian
☐ Pacific Islander
☐ Unknown
☐ Multiple Races (Please Specify) _____

Secondary or Emergency Contact Information:
Please list someone who can always provide us with your contact information if we lose touch with you:

Secondary or Emergency Contact Name:_____ Relation to you: _____

Address: _____
Street *Apt. #* *City* *State* *Zip*

Home Phone: _(_____)_____ Work Phone: _(_____)_____

Cell Phone: _(_____)_____ Email: _____

Your Concerns

What is your primary reason for coming to the Cancer Risk Evaluation Program? _____

_____

Are there any other concerns you would like addressed during your visit? _____

_____

Patient Label

Cancer History

Have you ever had any cancer, including DCIS (ductal carcinoma in situ)? ☐ Yes ☐ No

If yes, please complete the following chart. If you need more room, please use an additional sheet of paper.

Cancer Location/Type	Date of Diagnosis	Age at Diagnosis	Treatment Received (ex: surgery, chemotherapy, radiation)	Hospital Where Treated	Did this cancer recur?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Biopsy History

Have you ever had a biopsy? ☐ Yes ☐ No

If yes, please complete the following chart. If you need more room, please use an additional sheet of paper.

Biopsy	Have you ever had a biopsy?	How many biopsies have you had?	When did you have the biopsy?	At which hospital did you have the biopsy?	What were the results of the biopsy?
Breast	☐ Yes ☐ No				
Ovarian	☐ Yes ☐ No				
Prostate	☐ Yes ☐ No				
Skin	☐ Yes ☐ No				
Other: _____	☐ Yes ☐ No				
Polyp	**Have you ever had a polyp?**	**How many polyps have you had in total?**	**How old were you when first found to have polyps?**	**At which hospital were the polyps diagnosed?**	**What type of polyps did you have?**
Colon/Rectum	☐ Yes ☐ No				

Patient Label

Cancer Screening History

Please complete the following chart. If you need more room, please use an additional sheet of paper.

Breast	**Have you ever had screening?**	**Date of first screening**	**Frequency of screening**	**Date of Most Recent Screening**	**Have you ever had an abnormal screening?**
Clinical Breast Exam	☐ Yes ☐ No				☐ Yes ☐ No
Mammogram	☐ Yes ☐ No				☐ Yes ☐ No
Breast Ultrasound	☐ Yes ☐ No				☐ Yes ☐ No
Breast MRI	☐ Yes ☐ No				☐ Yes ☐ No
Ovarian	**Have you ever had screening?**	**Date of first screening**	**Frequency of screening**	**Date of Most Recent Screening**	**Have you ever had an abnormal screening?**
Transvaginal Ultrasound	☐ Yes ☐ No				☐ Yes ☐ No
CA-125 Test	☐ Yes ☐ No				☐ Yes ☐ No
Prostate	**Have you ever had screening?**	**Date of first screening**	**Frequency of screening**	**Date of Most Recent Screening**	**Have you ever had an abnormal screening?**
Digital Rectal Exam	☐ Yes ☐ No				☐ Yes ☐ No
PSA	☐ Yes ☐ No				☐ Yes ☐ No
Colon	**Have you ever had screening?**	**Date of first screening**	**Frequency of screening**	**Date of Most Recent Screening**	**Have you ever had an abnormal screening?**
Colonoscopy	☐ Yes ☐ No				☐ Yes ☐ No
Other: _____	☐ Yes ☐ No				☐ Yes ☐ No
Skin	**Have you ever had screening?**	**Date of first screening**	**Frequency of screening**	**Date of Most Recent Screening**	**Have you ever had an abnormal screening?**
Exam	☐ Yes ☐ No				☐ Yes ☐ No
Other	**Have you ever had screening?**	**Date of first screening**	**Frequency of screening**	**Date of Most Recent Screening**	**Have you ever had an abnormal screening?**
_____	☐ Yes ☐ No				☐ Yes ☐ No

Patient Label

General Health History

Gynecologic / Reproductive History

Have you ever used hormonal contraceptives (i.e. birth control pills)? ☐ Yes ☐ No
If yes, for how many years total (not counting periods of no contraceptive use)? _____
Have you ever been pregnant? ☐ Yes ☐ No
If yes, how many times have you been pregnant? _____
If applicable, at what age did you first give birth? _____
Have you ever used medication to help you get pregnant? ☐ Yes ☐ No
When was your last gynecologic exam? _____
Have you ever had your uterus surgically removed? ☐ Yes ☐ No
Have you ever had your ovaries surgically removed? ☐ Yes ☐ No

Menstrual History

Age at First Menstrual Period: _____
Have you had a menstrual period within the last year? ☐ Yes ☐ No
If no, age at last menstrual period: _____
Why have you not had your period within the last year?
☐ Natural menopause ☐ Chemotherapy/medication induced ☐ Surgery on reproductive organs
☐ Other: _____
Have you ever used hormone replacement therapy (HRT)? ☐ Yes ☐ No
If yes, for how long did you use HRT? _____

Breast History

Do you have a history of breast problems (other than cancer)? ☐ Yes ☐ No
If yes, what type (i.e. fibrocystic changes, benign tumors)? _____
Do you perform self-breast exams? ☐ Yes ☐ No
If yes, how often? _____
Do you have, or have you ever had, breast implants? ☐ Yes ☐ No

Gastrointestinal History

Do you have inflammatory bowel disease? ☐ Yes ☐ No Do you have Crohn's/ulcerative colitis? ☐ Yes ☐ No

Dermatologic History

Have you ever been diagnosed with any of the following non-cancer skin conditions? ☐ Yes ☐ No

☐ Keratoacanthoma	☐ Dysplastic Nevus	☐ Trichilemmoma
☐ Sebaceous Adenoma	☐ Papilloma	☐ Epidermal Cyst
☐ Melanoma-in-Situ	☐ Lipoma	☐ Other _____

Surgery History *Please complete the following chart. If you need more room, please use an additional sheet of paper.*

Surgery Location/Body Part	Date of Surgery	Procedure Done	Reason for Surgery	Hospital Where Treated

Patient Label

Smoking History

Have you ever smoked cigarettes? ☐ Yes ☐ No Do you currently smoke? ☐ Yes ☐ No

How many total years did you smoke (not counting periods of non-smoking)? _____

On average, how much did/do you smoke per day (1 pack = 20 cigarettes)? _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No If yes, on average, how much do you drink per week? _____

Physical Activity

Do you get regular exercise? ☐ Yes ☐ No If yes, how many times per week do you exercise? _____

Current Medications

Do you currently take any medications regularly? ☐ Yes ☐ No

If yes, please list medications below:

_____

_____

_____

Have you ever taken a medication to prevent cancer such as Tamoxifen (Nolvadex), Raloxifene (Evista), or Exemestane (Aromasin)? ☐ Yes ☐ No If yes, which medication? _____

Exposures

Are there any environmental exposures that you are aware of that might increase your cancer risks? ☐ Yes ☐ No

If yes, please list below:

_____

_____

_____

Other Health Concerns:

If you have any other major health concerns / problems please list below:

_____

_____

_____

_____

Please read the following instructions before beginning the FAMILY HISTORY QUESTIONNAIRE:

- When listing the name of any relative, be sure to include both the maiden and last name.
- If there is not enough space for all relatives to be listed, use a separate piece of paper.
- Please include all blood relatives even if they have **NOT** had cancer.
- You may need to ask other family members for help finding the information needed to complete this form.
- If you do not know exact dates, please estimate.

FOR EXAMPLE:

Name First, Last and Maiden Name	Current Age	Age at Death	Affected with Cancer? (yes or no)	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
YOUR MOTHER *Jane Jones (Smith)*	74		☒ Yes ☐	Breast	69	Community Medical Center Toms River, NJ
YOUR MOTHER'S MOTHER *Mary Smith (Doe)*		83	☒ Yes ☐	Colon	82	St. Joseph's Hospital, Anytown, PA

Genetic Testing ***Please include a copy of any genetic test results for you or your family members***

Have you ever had genetic testing (related to hereditary cancer risk)? ☐ Yes ☐ No

If yes, which gene(s) were tested? _____

What was the result? _____

Where was the testing done? _____

Has anyone else in your family had genetic testing (related to hereditary cancer risk)? ☐ Yes ☐ No

If yes, who in the family was tested? _____

Which gene(s) were tested? _____

What was the result? _____

Where was the testing done? _____

What is your ancestry on your mother's side of the family (original country of origin)? _____

Do you have any Jewish ancestry on your mother's side of the family? ☐ Yes ☐ No

What is your ancestry on your father's side of the family (original country of origin)? _____

Do you have any Jewish ancestry on your father's side of the family? ☐ Yes ☐ No

Patient Label

You, Your Parents, & Your Grandparents

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
You			☐ Yes ☐ No			
Your Mother			☐ Yes ☐ No			
Your Father			☐ Yes ☐ No			
Your Mother's Mother			☐ Yes ☐ No			
Your Mother's Father			☐ Yes ☐ No			
Your Father's Mother			☐ Yes ☐ No			
Your Father's Father			☐ Yes ☐ No			

Your Children

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Daughter #1			☐ Yes ☐ No			
Daughter #2			☐ Yes ☐ No			
Daughter #3			☐ Yes ☐ No			
Son #1			☐ Yes ☐ No			
Son #2			☐ Yes ☐ No			
Son #3			☐ Yes ☐ No			

Patient Label

Your Brothers and Sisters

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Sister #1			☐ Yes ☐ No			
Sister #2			☐ Yes ☐ No			
Sister #3			☐ Yes ☐ No			
Brother #1			☐ Yes ☐ No			
Brother #2			☐ Yes ☐ No			
Brother #3			☐ Yes ☐ No			

Your Nieces and Nephews

(Children of your Brothers & Sisters)

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Niece 1 / Parent			☐ Yes ☐ No			
Niece 2 / Parent			☐ Yes ☐ No			
Niece 3 / Parent			☐ Yes ☐ No			
Nephew 1 / Parent			☐ Yes ☐ No			
Nephew 2 / Parent			☐ Yes ☐ No			
Nephew 3 / Parent			☐ Yes ☐ No			

You may need to use an additional sheet of paper for other nieces or nephews

Patient Label

Your Aunts and Uncles

(Mother's Side)

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Mother's sister #1			☐ Yes ☐ No			
Mother's sister #2			☐ Yes ☐ No			
Mother's sister #3			☐ Yes ☐ No			
Mother's brother #1			☐ Yes ☐ No			
Mother's brother #2			☐ Yes ☐ No			
Mother's brother #3			☐ Yes ☐ No			

Your Aunts and Uncles

(Father's Side)

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Father's sister #1			☐ Yes ☐ No			
Father's sister #2			☐ Yes ☐ No			
Father's sister #3			☐ Yes ☐ No			
Father's brother #1			☐ Yes ☐ No			
Father's brother #2			☐ Yes ☐ No			
Father's brother #3			☐ Yes ☐ No			

Patient Label

Maternal Cousins

(Children of Your Mother's Brothers & Sisters)

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Cousin #1 / Parent			☐ Yes ☐ No			
Cousin #2 / Parent			☐ Yes ☐ No			
Cousin #3 / Parent			☐ Yes ☐ No			
Cousin #4 / Parent			☐ Yes ☐ No			
Cousin #5 / Parent			☐ Yes ☐ No			
Cousin #6 / Parent			☐ Yes ☐ No			

Paternal Cousins

(Children of Your Father's Brothers & Sisters)

Name (First, Last and Maiden Name)	Current Age	Age at Death	Affected with Cancer?	Location of Cancer (Breast, Lung, etc)	Age at Cancer Diagnosis	Hospital, City where Cancer Diagnosed
Cousin #1 / Parent			☐ Yes ☐ No			
Cousin #2 / Parent			☐ Yes ☐ No			
Cousin #3 / Parent			☐ Yes ☐ No			
Cousin #4 / Parent			☐ Yes ☐ No			
Cousin #5 / Parent			☐ Yes ☐ No			
Cousin #6 / Parent			☐ Yes ☐ No			

Completed by: _____ Date: _____ Time: _____

Reviewed by: (Print) _____ Date: _____ Time: _____

Signature: _____

Patient Label