



Genetic Risk Evaluation and Testing Program  
9555 SW Barnes Rd. STE 150  
Portland, OR 97225  
Phone: 503-297-7403 Fax: 503-297-3470  
Personal and Family History Questionnaire

**Please fill out and return this form by mail in the addressed/stamped envelope (Medical records 265 N Broadway, Portland, OR 97227) no later than the Friday before your appointment date. Or fax to 503-297-3470**

**If this form is not mailed a week before your appointment, please call 503-297-7403 to reschedule.**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Referring Healthcare Provider: \_\_\_\_\_

Reason for referral: \_\_\_\_\_

Gender at birth: Female / Male                      Gender identity: Female/Male/transgender/\_\_\_\_\_

Are you adopted? YES    NO            Are you a twin? YES    NO, if yes -are you identical or fraternal? Circle one

**Ancestry: Please select all that apply**

**Mother's Side**

- Western/Northern European     Jewish
- Central/Eastern European        African
- Middle Eastern                     Asian
- Latin American/Caribbean     Native American

**Father's Side**

- Western/Northern European     Jewish
- Central/Eastern European        African
- Middle Eastern                     Asian
- Latin American/Caribbean     Native American

Please list any *hereditary cancer genetic testing* you or your family members have had.

**If a family member has previously been tested, please obtain a copy of their results.** A copy of results will be needed in order for you to proceed with testing for any known mutation in the family. It is helpful to obtain all family members genetic reports even if negative:

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**Note: If you have death certificates or pathology reports on family members with cancer or pre-cancer, please include with packet**



**Your Personal Health History**

**Cancer history:**

- Do you have a current or past diagnosis of cancer? YES NO  
If the answer is yes, please answer these questions, if no then proceed to endoscopy history.  
What type of cancer? \_\_\_\_\_  
What age were you when you were diagnosed? \_\_\_\_\_  
What treatments did you receive for this cancer? (surgery, radiation, chemotherapy, hormonal)  
\_\_\_\_\_  
Have you ever had any other cancers, either current or past? YES NO  
Please list type and age(s) at diagnosis:  
\_\_\_\_\_  
\_\_\_\_\_

**Endoscopy history:**

- Have you ever had a colonoscopy? YES NO
- Age at first colonoscopy \_\_\_\_\_ Date of last colonoscopy \_\_\_\_\_  
Have you ever had Colon Polyps? YES NO  
Age at first colon Polyp \_\_\_\_\_ Total Number of colon Polyps \_\_\_\_\_  
Type of Polyp (If known) \_\_\_\_\_
- Have you ever had an upper endoscopy? YES NO

**Habits/Social history**

Have you ever smoked? YES NO. If Yes, How many packs per day \_\_\_\_\_  
Age started \_\_\_\_\_ Age stopped \_\_\_\_\_  
Do you drink alcohol? YES NO. If Yes, How many drinks per week? \_\_\_\_\_  
Occupation: \_\_\_\_\_ Retired? YES/NO  
Relationships: Single/Significant other/ Partnered/Married/ \_\_\_\_\_ circle or fill in the blank

**For Women:**

Age periods started? \_\_\_\_\_ Age at Menopause? \_\_\_\_\_ Circle one: Surgical/Cancer treatment/Natural  
#of pregnancies \_\_\_\_\_ #of live births \_\_\_\_\_ Number of C-sections \_\_\_\_\_  
At what age did you have your first child? \_\_\_\_\_ Did you breast feed for longer than 1 month? YES NO  
History of abnormal pap smears? YES NO Age if yes \_\_\_\_\_  
Have you ever taken hormones for menopause? YES NO Type \_\_\_\_\_ How long? \_\_\_\_\_  
Have you ever taken oral contraceptives? YES NO Total # years taken \_\_\_\_\_  
Date (Month/Year) of most recent mammogram \_\_\_\_\_  
Have you ever had a breast biopsy? YES NO # of biopsies \_\_\_\_\_  
Was your biopsy normal or abnormal? \_\_\_\_\_ Check here if Unknown \_\_\_\_\_



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1. Please List surgeries and year surgery completed:

Surgery	Year of surgery

2. Please list any medical history

Condition	Year diagnosed

3. Please list any allergies to medications:

\_\_\_\_\_

4. Please list medications:

Medication	Dosage	Frequency



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**This next section is about your PARENTS and GRANDPARENTS - please list all biological relatives including relatives without a history of cancer**

<b>Parents and Grandparents</b>	First Name	Living? Circle one	Cancer YES NO circle one Type: list type if Yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Mother		YES NO	YES NO Type:		
Your Mother's Mother		YES NO	YES NO Type:		
Your Mother's Father		YES NO	YES NO Type:		
Father		YES NO	YES NO Type:		
Your Father's Mother		YES NO	YES NO Type:		
Your Father's Father		YES NO	YES NO Type:		



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**This next section is about your CHILDREN- please list all biological children including those without a history of cancer**

Please indicate if any of your children are twins. Please note if they are identical twins or fraternal twins. If your child is adopted, please specify if they are related to someone else in the family.

<b>Your Biological Children</b>	First Name	Living? Circle one	Cancer YES NO circle one Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And #daughters Your child has -Use 0 if none
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:
Circle one Son/daughter		YES NO	YES NO Type:			Sons: Daughters:



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**This next section is about your SIBLINGS - please list all biological siblings including those without a history of cancer**

**Your Siblings:** How many full sisters \_\_\_\_\_ How many full brothers \_\_\_\_\_  
 How many half- sisters \_\_\_\_\_ How many half -brothers \_\_\_\_\_  
 Please indicate if any siblings are twins. And if twins, note if they are identical.

<b>Please select full or half sib and if half sib, circle shared parent</b>	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And # daughters each sibling has -Use 0 if none
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
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**This next section is about your MOTHER'S SIBLINGS - please list all biological aunts and uncles including those without a history of cancer**

**Your Mother's siblings:**  
 How many full sisters \_\_\_\_\_ and brothers \_\_\_\_\_ does your mother have?  
 How many half- sisters \_\_\_\_\_ How many half -brothers \_\_\_\_\_  
 Please indicate if any siblings are twins. And if twins, note if they are identical.

<b>Please select full or half sib and if half sib, circle shared parent</b>	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters each relative has. -Use 0 if none
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:



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List **your first Cousins** on your **MOTHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer.**

<b>Circle gender and write first Name of each</b>	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

**Add any additional maternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known**

<b>Circle gender and write first Name of each</b>	How are they related to you? (Ex: Mother's maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		





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**This next section is about your FATHER'S SIBLINGS - please list ALL biological aunts and uncles including those without a history of cancer**

**Your father's siblings:**  
 How many full sisters \_\_\_\_\_ and brothers \_\_\_\_\_ does your father have?  
 How many half- sisters \_\_\_\_\_ How many half -brothers \_\_\_\_\_  
 Please indicate if any siblings are twins. And if twins, note if they are identical.

<b>Please select full or half sib and if half sib, circle shared parent</b>	Circle gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters Each relative has. -Use 0 if none
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:
<input type="checkbox"/> Full <input type="checkbox"/> Half: If half sib, circle shared parent Mother/Father	Male/Female  First name:	YES  NO	YES NO Type:			Sons:  Daughters:



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<b>Circle gender and write first Name of each</b>	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		

**Add any additional paternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known**

<b>Circle gender and write first Name of each</b>	How are they related to you? (Ex: fathers, maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		
Male/Female First name:		YES/NO	YES NO Type:		