Genetics and Risk Assessment Clinic

You have been scheduled for an appointment on _____
Expect your appointment to last approximately 1 hour.

You will meet with: ☐ Julie Thompson, ARNP
☐ Julie Shaw, DNP, ARNP, ANP-C, GNP-BC

If you are unable to keep your appointment, please call us at **319-558-4876**.

What to bring:

- Photo ID
- Insurance Card
- Copays are due at the time of your visit
- **Completed** family history packet
- **Any genetic testing reports from other family members**

Where: The Genetics Clinic is located within the **Nassif Community Cancer Center,** which is on the 2nd floor of the **PCI Medical Pavilion 1 at 202 10th St. SE, Suite 285 in Cedar Rapids.**
During your appointment we will be discussing your personal and family medical history. It is very important that you complete this history form to the best of your ability. You may need to contact your family members in order to collect the most accurate information. Please bring this completed form with you when you come to your first appointment. **If you are unable to complete the questionnaire or if you have questions about it, please give us a call.** There are many reasons that it may not be possible to complete the entire form. If this is the case, don't worry. If you would like to bring someone into your counseling session, we encourage you to bring a support person.

Information to be gathered:

- Current age or age at death of all your relatives including children, parents, brothers and sisters, nieces and nephews, aunts and uncles, cousins, and grandparents.
- It's important to list **all** family members, even if they did **NOT** have any medical issues.
- If they did have cancer, what type of cancer did they have? How old were they at the time of diagnosis?
- Has anyone in the family had genetic testing? If so, please bring a copy of those results with you to the appointment.

MEDICAL HISTORY FORM

Name: _____ DOB: _____

Ancestry Background: _____

Do you have any Ashkenazi Jewish background? Yes ___ No ___

Do you have any MAJOR medical conditions? Please List:

_____

_____

_____

_____

Past Surgical History: (include type of surgery, year, and hospital)

_____

_____

_____

_____

Cancer History

Have you ever been diagnosed with cancer? Y N

Diagnosis: _____ Age: _____

Treatment: _____

Institution: _____

Diagnosis: _____ Age: _____

Treatment: _____

Institution: _____

Diagnosis: _____ Age: _____

Treatment: _____

Institution: _____

Past OB/GYN History:
Age periods started: _____ Last menstrual period: _____
Number of births: ____Age at first birth: ____
Are you currently using any form of contraceptives? Y N
If yes, what form are you using? : _____
Have you used hormonal contraceptives in the past? Y N How many years? _____

Do you perform self-breast exams? Y N Age at first mammogram: _____
Last mammogram: _____ Number of past breast biopsies: _____
Any history of abnormal mammograms? Y N If yes, where was it done? _____

Have you ever had a breast MRI? Y N

Have you had any screening for ovarian cancer? Y N
If **yes**, please answer the following:
Have you had a CA-125 blood test? Y N Date of most recent test: _____
Results: _____
Have you had a transvaginal ultrasound? Y N Date of most recent scan: _____
Have you had screening for endometrial (uterine) cancer? Y N
If **yes**, please answer the following:
Have you had a transvaginal ultrasound? Y N Date of most recent scan: _____

Have you had a hysterectomy? Y N Age: _____Were your ovaries removed? Y N
Age at menopause: _____
Are you currently using hormone replacement therapy? Y N
Have you ever used hormone replacement therapy? Y N
What is the total amount of time you used these medications? _____years_____months
Have you used any natural or herbal products to deal with the symptoms of menopause?
If **yes**, what have you used? _____

Past Urologic History:
Have you started prostate cancer screening? Y N
When was your last PSA? _____ Results: _____
When was your last prostate exam? _____
Have you ever had an elevated PSA? Y N

Other Cancer Screening History
Colon
Have you ever had a colonoscopy? Y N Date: _____

Do you have any history of colon polyps? Y N How many? 0-5 5-10 10-20 20 or more

Skin
Have you had any pre-cancerous or cancerous moles removed? Y N
Do you see a dermatologist yearly for screening? Y N

Social History

Do you currently use tobacco? Y N

Cigarettes: Amount/day_____ Years used: _____

Have you used tobacco in the past, but have now quit? Y N

When did you quit? _____

How many years did you use? _____

Do you use alcohol? Y N Number of drinks/week:_____

Occupation: _____ Are you retired? Y N

Have you had any exposure to any chemicals or substances that are known to be harmful (asbestos, radiation, second- hand smoke, DES, etc.)? Y N

If **yes**, what? _____

Genetic History

Have you ever been diagnosed with a genetic condition? Y N

Please list your diagnosis: _____

Have you ever had a genetic test? Y N

For what condition: _____

What was the result: _____

Have any of your family members had genetic testing done? If so, what kind, and what were the results?

_____

_____

_____

_____

_____

On the following pages please list ALL of your family members, regardless if they have had cancer or not. It is important for us to be aware of how big your family is in order to do a complete risk assessment.

Please be as specific as you can about the ages of your family members, especially their age when they were diagnosed with cancer, and their age at death.

Having this information helps us to give you the most accurate risk assessment and helps to determine if genetic testing would be helpful for the family.

YOUR CHILDREN

Name	Male/ Female	Age at death or current age	Cancer diagnosis	Age at diagnosis	Major medical conditions

YOUR BROTHERS AND SISTERS

Name	Male/ Female	Age at death or current age	Cancer diagnosis	Age at diagnosis	major med. conditions	Your brothers' and sisters' children
						# Daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____

YOUR MOTHER'S FAMILY ***YOUR MOTHER'S COUNTRY OF ORIGIN*: _____**

Name	Male/ Female	Age at death Or current age	Cancer diagnosis	Age at diagnosis	major med. conditions	
Your mother	F					
Your mother's mother	F					
Your mother's father	M					
Your mother's brother's And sisters						# daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						# Daughters: _____ Ages: _____ # Sons: _____ Ages: _____

YOUR FATHER'S FAMILY ***YOUR FATHER'S COUNTRY OF ORIGIN*: _____**

Name	Male/ Female	Age at death Or current age	Cancer diagnosis	Age at diagnosis	major med. conditions	
Your father	M					
Your father's mother	F					
Your father's father	M					
Your father's brother's And sisters						# daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						#daughters: _____ Ages: _____ # Sons: _____ Ages: _____
						# Daughters: _____ Ages: _____ # Sons: _____ Ages: _____

OTHER RELATIVES WITH MEDICAL ISSUES

Name	Male/ Female	Age at death Or current age	Cancer diagnosis	Age at diagnosis	Relationship	major medical conditions