Yourself:

Occupation _____ Your partners occupation _____

Do you smoke? YES / NO If **Yes** how many per day? _____

Some types of genetic cancer are slightly more common in Jewish families.

Are you or any of your family Jewish? YES / NO

What are the main points would like to discuss with us?

_____

_____

_____

If you have <u>not</u> had cancer yourself:

What do you think your risk of developing cancer is compared with someone in the general population?

Much less ☐ Slightly less ☐ Same as ☐ Slightly higher ☐ Much higher ☐

What do you think your chances are of developing this cancer in your lifetime?
Please mark on the line with an arrow

No chance of getting cancer 0% 50% 100% Complete certainty of getting cancer

Please complete this section if you have a family history of BOWEL cancer

- Have you ever had a colonoscopy or other bowel screening? YES / NO

  If **Yes** – when was your last one? _____

  Where was it done? _____

Please complete this section only if you are a woman who has a family history of BREAST or OVARIAN cancer.

- At what age did your periods start? _____
- Do you have any children? YES / NO If so how old were you when your first child was born? _____
- Are you taking the contraceptive pill? YES / NO
- For how many years have you been taking the contraceptive pill (if at all)? _____
- Are you taking Hormone Replacement Therapy (HRT)? YES / NO If **Yes**, for how long? _____
- Have you ever had a scan of your ovaries? YES / NO

  If **Yes** – when was your last one? _____

  Where was it done? _____
- Have you ever had a mammogram? YES / NO

  If **Yes** – when was your last one done? _____

  Where was it done? _____
- Have you ever had any problems with your breasts? If so please describe nature including dates, hospital and names of specialists seen. _____

  _____

Thank you for completing this questionnaire.

Family History Sheet

We would be grateful if you would complete this questionnaire, which will help us to assess whether or not your family history places you at increased risk.

Thank you.

Name: _____ Mr/Mrs/Ms/Miss Date of Birth: _____

Address: _____

_____ Postcode: _____

Telephone No: _____ Mobile Telephone No: _____

If we require further information are you happy for us to contact you by telephone? YES NO

Do you have an answerphone? If so are you happy for us to leave a message? YES NO

If you have a partner are they aware of this referral? YES NO

Your partner's name: _____

GP Name: _____ Tel No: _____

GP Address: _____

_____ Postcode: _____

For official use only

Genetic number: _____

Date issued: _____ Date returned: _____

Please complete 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; if you are unable to complete all sections, then please return the form giving as much information as you can; and if you only know the month or year of any requested dates, please give those. Please continue on additional sheets of paper if necessary.

Have any of your relatives already been seen by a Genetics Service? If so could you please tell us:

Name of relative seen: ……..

Which Genetics Service did they attend?: (Town/City ?) ……..

	Name (including maiden/previous names) and last known address	Date of Birth	Alive Y/N	Date of Death	If your relative had cancer:			
					Type of Cancer	Age at diagnosis	Hospital where treated (+ specialist if known & town or city)	For official use only
Yourself								y
Your mother								m
Your father								f
Your own children								c
Your sisters Full or half*								s
	* if half please state through mother or father							
Your brothers Full or half*								b
	* if half please state through mother or father							
Your mother's mother								mm
Your mother's father								mf
Your mother's brothers & sisters								mb/ms
Your father's mother								fm
Your father's father								ff
Your father's brothers & sisters								fb/fs
Other family members affected with cancer								