

## PATIENT INFORMATION

# Breast Care Unit

## Family History Questionnaire

The information you provide in this questionnaire will help us to assess whether your risk of inheriting a genetic alteration which increases the risk of breast cancer is raised. Please complete the enclosed forms giving as much information as possible and return to me at the address above.

It is important to include all family members whether or not they have cancer.

### **We want to know details about:**

- Yourself
- Your 1st degree relatives (your children, your brothers, sisters and your parents). You can include any half-brothers and sisters in this section.
- Your 2nd degree relatives (aunts, uncles, grandparents, nephew and nieces).
- Other more distant relatives (for example: cousins who have cancer).

### **For each family member who has been affected by cancer, we need to know:**

- The type of cancer and the age at diagnosis
- Are they alive and if so their present age?
- If they are deceased, the age when they died

Following your assessment, we will advise you if you meet the criteria for average risk (also known as near population risk), moderate risk, or if you are in the higher probability category. You may be entitled to early or additional breast screening and further discussions around genetic testing.

Yours sincerely  
Lynn Whittaker  
Advanced Nurse Practitioner

## 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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Mobile Tel 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

Hos No: \_\_\_\_\_

Date Issued: \_\_\_\_\_ Date Returned: \_\_\_\_\_

Please complete giving as much detail 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. 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 you or 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) \_\_\_\_\_

Outcome: \_\_\_\_\_

	Name (Including maiden/previous names) and last known address	Date of birth	Alive Y/N	Date of death	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. If half, please state through mother or father								s
Your brothers, full or half. If half, please								b

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 by cancer – Please specify which side of the family.								

## About You:

Occupation: \_\_\_\_\_

Do you smoke? YES / NO If yes, how many per day? \_\_\_\_\_

Do you drink any alcohol? Yes / No If yes, how many units per week? \_\_\_\_\_

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 you would like to discuss with us?

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If you have NOT 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 ONLY if you are a woman who has a 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? 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:

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For further assistance or to receive this information in a different format, please contact the department which created this leaflet.