

Patient Name

DOB:

MR #

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Date: _____

UW Health uwhealth.org
(University of Wisconsin Hospitals and Clinics Authority)
ONCOLOGY GENETICS NEW PATIENT
QUESTIONNAIRE - MALE

Welcome to the Cancer Genetics Risk Assessment and Counseling Program at the UW Health. You have been referred because of your personal and/or family history of cancer.

We need information about your personal and family medical history to help us prepare for your visit. We understand if you do not know the answers to all of these questions, but the more information you are able to provide, the better we will be able to assess your situation.

Please complete this form and return it to: UW Health Cancer Genetics Clinic
600 Highland Ave., K4/212
Madison, WI 53792
Attn: Department Assistant

An addressed postage paid envelope is enclosed. Alternatively, you can fax the form to 608-662-4448. If you have any questions, please call our office at 608-263-7284. **After we receive your form, we will contact you to set up an appointment with one of our genetic counselors.**

Please bring any medical records to your appointment that you think might be useful, **especially genetic test reports**. These could be your own medical records or records of your relatives.

Your Health Care Team	Primary Care Provider:	
	Referring Provider:	
	Oncologist (if appropriate):	

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PERSONAL HEALTH HISTORY

Have you ever been diagnosed with cancer? Yes No

Type of Cancer (e.g. colon, prostate, stomach, Hodgkins, etc.)	Age Diagnosed	Type(s) of treatment you received (e.g. surgery, radiation, chemo)

Personal Cancer Screening History

1) Are you routinely screened for prostate cancer with the PSA blood test (PSA = Prostate Specific Antigen)?

Yes No

2) Have you ever had a colonoscopy? Yes No

If YES, how many colonoscopies have you had? _____

How old were you when you had your first one? _____

Have polyps been found? Yes No If YES, how many? _____

Past Medical History:

1) What is your current weight? _____ lbs. How tall are you? _____ ft. _____ in. Have you ever been told you have low bone density (e.g. osteopenia or osteoporosis)? Yes No If YES, are you on any medications? _____

2) Have you ever been told that you have any of the following health problems?

Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain _____
Liver problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain _____
Kidney problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain _____
Heart problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please explain _____
High Blood Sugar (Diabetes)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
High Blood Pressure (Hypertension)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

3) In the space below, please describe any other health problems or illnesses that you have been treated for:

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Social History:

1) What is your current occupation? _____

2) Do you or have you ever smoked cigarettes? Yes No If YES, how old were you when you started? _____

If YES, on average, how many cigarettes did/do you smoke each day? (Please circle)

None 1-2 < 1/2 pack 1-2 pack(s) > 2 packs

If you no longer smoke, please indicate how old you were when you quit? _____

3) On average, how many servings of alcohol (wine, beer, liquor) do you drink each week?

None 1-2 3-4 4-7 7-14 >14

4) On average, how many days per week do you currently get at least 30 minutes of exercise?

(Include only activity equal or greater than a brisk walk)

None 1-2 3-4 5-7

Genetic Testing:

1) To your knowledge, has anyone in your family met with a genetic counselor to discuss the family history of cancer?
 Yes No

2) To your knowledge, has anyone in your family had **genetic testing** for any cancer risk genes (i.e. *BRCA1*, *BRCA2*, *PALB2*, etc.)? Yes No

If YES, who was this person/how are they related to you? _____

If YES, was the testing positive for: BRCA1 BRCA2 Other, please explain _____

If YES, when was the testing done? _____

If YES, where was the testing done? _____

If someone in your family has tested positive for a cancer gene mutation, please include a copy of your family member's test report if at all positive. This is essential if test results were positive.

What questions do you hope we may be able to address during your appointment?

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FAMILY HISTORY

Please include all members of your family, not just those that have had cancer.
If you need more room, please continue on the back page of this packet.

PART 1: YOUR CHILDREN

Child's First Name	Gender (M or F)	Age	✓ if deceased	Type of Cancer (leave blank if person has no history of cancer)	Age at Cancer Diagnosis (if applicable)

Do any of the children above have a different father or mother? If YES, please clarify:

PART 2: YOUR BROTHERS AND SISTERS

First Name	Gender (M or F)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis	His/Her Children (your nieces/nephews)	
						Name	Cancer Type and Age of Diagnosis

Do any of your brothers or sisters have a different father or mother? If YES, please clarify:

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PART 3: YOUR PARENTS AND GRANDPARENTS

Your Mother's First Name	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis
Maternal Grandmother's First Name (your mother's mother)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis
Ethnic Background of your maternal grandmother (English, Irish, German, etc.):				
Maternal Grandfather's First Name (your mother's father)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis
Ethnic Background of your maternal grandfather (English, Irish, German, etc.):				
Your Father's First Name	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis
Paternal Grandmother's First Name (your father's mother)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis
Ethnic Background of your paternal grandmother (English, Irish, German, etc.):				
Paternal Grandfather's First Name (your father's father)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis
Ethnic Background of your paternal grandfather (English, Irish, German, etc.):				

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PART 4: YOUR MATERNAL AUNTS, UNCLES AND COUSINS

First Name of mother's sisters and brothers	Gender (M or F)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis	His/Her Children (your cousins)	
						Name	Cancer Type and Age of Diagnosis

Do any of the above aunts and uncles have a different father or mother? If YES, please clarify:

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PART 5: YOUR PATERNAL AUNTS, UNCLAS AND COUSINS

First Name of father's sisters and brothers	Gender (M or F)	Age or age at death	✓ if deceased	Type of Cancer (if any)	Age at Cancer Diagnosis	His/Her Children (your cousins)	
						Name	Cancer Type and Age of Diagnosis

Do any of the above aunts and uncles have a different father or mother? If YES, please clarify:

PLEASE LIST ANY OTHER MATERNAL OR PATERNAL FAMILY MEMBERS WITH CANCER:

Signature of Patient/Representative: _____ Date: _____ Time: _____ AM/PM

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: Minor Incompetent/Incapacitated
Legal Authority: Legal Guardian Parent of Minor
 Health Care Agent Other _____

Reviewed by: _____ Date: _____ Time: _____ AM/PM