Patient Name:

DOB:

MR #:

UW Health
(University of Wisconsin Hospitals and Clinics Authority)

ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE

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Date: _____

Please fill in the blanks below to the best of your ability.

Please list any cancer diagnosis and/or tumors you have had:

_____

_____

_____

Have you ever had genetic testing before: ☐ Yes ☐ No

What was the result? _____

Have any of your family members had genetic testing before? ☐ Yes ☐ No

What was the result? _____

If you or any of your family members have had genetic testing it is VERY IMPORTANT to bring a copy of the test results (from the lab that did the testing) to your appointment – even if everything was normal

FAMILY HISTORY

Please fill in the blanks below. If additional space is needed, please attach a separate sheet of paper.

Do you have **Children?** ☐ Yes ☐ No How many Sons: _____ Daughters: _____

Please name your children, starting with any who have had cancer. You may include deceased children:

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

Do you have **Siblings?** ☐ Yes ☐ No How many brothers: _____ Sisters: _____

Please name your brothers and sisters, starting with any who have had cancer. You may include deceased siblings:

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

Is your **Mother** still living? ☐ Yes ☐ No Age/Age at death: _____

Did she have cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

Does your **Mom** have siblings? ☐ Yes ☐ No How many Brothers: _____ Sisters: _____

Please name your aunts and uncles (your mother's siblings), starting with any who have had cancer. You may include deceased relatives:

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

First Name: _____ Age: _____ Cancer type: _____ Age at diagnosis: _____

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Is your Mom's mother (your **grandma**) still living?	☐ Yes ☐ No		Age/Age at death: _____
Did she have cancer?	☐ Yes ☐ No	Cancer type: _____	Age at diagnosis:_____
Is your Mom's father (your **grandpa**) still living?	☐ Yes ☐ No		Age/Age at death: _____
Did he have cancer?	☐ Yes ☐ No	Cancer type: _____	Age at diagnosis: _____

Is your **Father** still living?	☐ Yes ☐ No		Age/Age at death: _____
Did he have cancer?	☐ Yes ☐ No	Cancer type: _____	Age at diagnosis: _____
Does your **Dad** have siblings?	☐ Yes ☐ No	How many Brothers: _____	Sisters: _____

Please name your aunts and uncles (your father's siblings), starting with any who have had cancer. You may include deceased relatives:

First Name: _____	Age: _____	Cancer type: _____	Age at diagnosis: _____
First Name: _____	Age: _____	Cancer type: _____	Age at diagnosis: _____
First Name: _____	Age: _____	Cancer type: _____	Age at diagnosis: _____
First Name: _____	Age: _____	Cancer type: _____	Age at diagnosis: _____

Is your Dad's mother (your **grandma**) still living?	☐ Yes ☐ No		Age/Age at death: _____
Did she have cancer?	☐ Yes ☐ No	Cancer type: _____	Age at diagnosis:_____
Is your Dad's father (your **grandpa**) still living?	☐ Yes ☐ No		Age/Age at death: _____
Did he have cancer?	☐ Yes ☐ No	Cancer type: _____	Age at diagnosis: _____

Please list your ancestry/background on your MOM's side: (i.e. German/Asian/African American/Jewish)

Please list your ancestry/background on your DAD's side:

Please list any other family members (maternal or paternal) with cancer:

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

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: _____