University Hospital Southampton NHS
NHS Foundation Trust

Wessex Clinical Genetics Service
Princess Anne Hospital
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Southampton
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Date .....

CANCER FAMILY HISTORY QUESTIONNAIRE

This form MUST be accompanied by a referral from a healthcare professional.

NOTE FOR GPs: Please complete this form and submit on eRS to 7939141 Genetics - Cancer - (Triage) - Southampton - UHSFT - RHM – PAH

You have been referred to the Wessex Clinical Genetics Service because of a family history of cancer.

Please complete this questionnaire to help us assess this for you. All information you give will be kept as part of your NHS record and will be kept confidential.

If you have any queries or difficulties in completing the form, please do not hesitate to contact us. If you are unable to complete all the sections, please still return the form. If you do not know exact dates of birth, or age of diagnosis, please put approximate dates or ages.

Please return this questionnaire as soon as possible for us to process all the information and get back to you.

Title: _____ Forename(s): _____ Surname: _____

Previous surname(s): _____

Name you prefer to be addressed by (optional): _____ Pronouns (optional): _____

Address: _____

Telephone number: _____

Email Address: _____

We may contact you by telephone if we need further details. We will not disclose where we are calling from to anyone apart from yourself, without your permission.

- Are you happy for us to contact you by telephone? YES/NO
- If you have an answer-phone are you happy for us to leave a message? YES/NO
- Can we disclose where we are calling from should anyone apart from you answer the phone? YES/NO
- Would you prefer to receive a letter, asking to call the department, should we need further details? YES/NO

If you know of anyone else in your family who has been seen by another Genetics Service or referred to Wessex Clinical Genetics Service, it would be helpful to provide some details here:

Name: Date of birth:

Genetics Service where seen:

Diagnosis:

We may get in touch asking you to pass on a consent form to your relative to access their genetic report. Are you in contact with the above relative? YES/NO
If you already have a copy of this genetic result, it would be helpful to return this form with a copy attached.

Your immediate family - We would like to know details of family members, both with and without cancer diagnoses

Please note any additional information, such as donor conception, adoption, or anything else you would like us to understand about this part of your family:

_____

_____

Relative	**Name** (including any previous names)	Date of Birth	Alive Y/N	Date of Death	If you/your relatives suffered from cancer		
					Type of Cancer	Age of Diagnosis	Hospital where treated
You							
Your Children							
Your Sisters, full or half (if half, please state through mother or father)							
Your Brothers, full or half (if half, please state through mother or father)							
Your Mother							
Your Father							

Your paternal family history: people related to you through your biological father

Please note any additional information, such as donor conception, adoption, or anything else you would like us to understand about this side of your family:

_____

_____

Relative	**Name** (including any previous names)	Date of Birth	Alive Y/N	Date of Death	If your relatives suffered from cancer		
					Type of Cancer	Age of Diagnosis	Hospital where treated
Your father's mother							
Your father's father							
Your Father's Siblings (Please state whether half or full – if half state through which parent)							
Any other paternal relatives with cancer? Please state how they are related to you (Father's brother's daughter etc.).							

Your maternal family history: people related to you through your biological mother

Please note any additional information, such as donor conception, adoption, or anything else you would like us to understand about this side of your family:

_____

_____

Relative	**Name** (including any previous names)	Date of Birth	Alive Y/N	Date of Death	If your relatives suffered from cancer		
					Type of Cancer	Age of Diagnosis	Hospital where treated
Your Mother's Mother							
Your Mother's Father							
Your Mother's Siblings (Please state whether half or full – if half state through which parent)							
Any other maternal relatives with cancer? Please state how they are related to you (Mother's brother's son etc.).							

About you

Some conditions are more common in certain ethnic groups. What is your ethnicity? _____

Some types of inherited cancers are more common in Jewish families. Are you or any of your immediate family Jewish? YES/NO

If **you have had cancer,** please give us details including dates, hospital and names of specialists seen and any treatment you have had.

Please complete this section only if you were assigned female at birth and have a family history of BREAST or OVARIAN cancer.

Are you taking the contraceptive pill? YES / NO If **Yes**, for how many years? _____

At what age did you go through menopause? _____ (if appropriate)

Are you taking Hormone Replacement Therapy (HRT)? YES / NO If **Yes**, for how many years? _____

Have you ever had a mammogram? YES / NO If **Yes**, when was your last one?

Have you ever had any problems with your breast tissue? If so please describe nature including dates, hospital and names of specialists seen:

Is there **any other information** about you or your family members that you feel may be relevant?

What are **your main questions** you would like to be addressed by the genetics service?

Thank you for completing this questionnaire

For official use only	**G Number:**
Date Issued:	**Date Returned:**
Patient Number:	