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| **Template: Family history questionnaire**Assessment for cancer genetics services | **<Name of outpatient clinic>**<Address of clinic><Phone, fax and email of clinic> |

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| This questionnaire is to be completed by you, the patient. |
| On referral to a cancer genetic service, information about your personal and family history of cancer is collected and entered into a NSW genetics database. At your appointment we will talk about our assessment of your family history and any health recommendations. A small number of families may need genetic testing.  |

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| **Patient details**  |
| Patient name: | Address: |
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| Title: | Mr  Mrs  Ms  Miss  |  |
| Medicare number: |  | Date of birth: | / / |
| Sex/gender: | **M** (male)  **F** (female)  **X** (indeterminate/intersex/unspecified)  |
| Phone: | W (work) H (home) M (mobile) |
| Email: |  | Communication preference:Phone W  Phone H  Phone M  Email  |
| Carer name (if appropriate): | Phone: |  |
| Email: |  |
| Identifies as of Aboriginal or Torres Strait Islander origin: | Yes  | No  | Interpreter required: | Yes  | No  |
| Language: |
| Special needs/reasonable adjustmentsrequired for disability: | Yes  | No  | Description of required adjustments: |
| GP name: | Phone: |  |
| Email: |  |
| *Please list below any specialist or doctor that has been part of your current and ongoing care. As a matter of courtesy we will advise these specialists or doctors of your treatment and care management process.* |
| Specialist doctor: | Phone: |  |
|  | Email: |  |
| Specialist doctor: | Phone: |  |
|  | Email: |  |
| Specialist doctor: | Phone: |  |
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| **Personal History**  |
| Have you been diagnosed with a cancer/tumour? | Yes  No  *If yes, please complete below* |
| Have you ever had bowel polyps?  | Yes  No  *If yes, please complete below* |
| Type of cancer/tumour/polyps you have had | Age at diagnosis | Surgery/treatment | Doctors name | Hospital where treated |
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| **Family History**  |
| What is your families’ ethnic origin? | Mothers side:  | Fathers side: |
| Do you have any Jewish ancestry? Yes  No   | Mothers side: Yes  No   | Fathers side: Yes  No  |
| Has anyone in your family seen a genetic service before? Yes  No  unknown  *If yes, please complete below* |
| Name of family member who was seen | Relationship to you | Which genetic service did your family member attend |
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| Family history (please list all your relatives including those who have not had cancer) |
| Relative | Gender (M/F) | First name | Last name | Date of birth/ age | Alive (Y/N) | Date of death/age | Type of cancer/tumour/polyps diagnosed? | Age at diagnosis | Hospital where treated |
| You |  |  |  |  | Y | N/A | See previous page |  |  |
| Mother | F |  |  |  |  |  |  |  |  |
| Father | M |  |  |  |  |  |  |  |  |
| Your children |  |  |  |  |  |  |  |  |  |
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| Your brothers and sisters |  |  |  |  |  |  |  |  |  |
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| Mother’s mother | M |  |  |  |  |  |  |  |  |
| Mother’s father | F |  |  |  |  |  |  |  |  |
| Father’s mother | M |  |  |  |  |  |  |  |  |
| Father’s father | F |  |  |  |  |  |  |  |  |

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| Family history continued *(please list all your relatives including those who have not had cancer)* |
| Relative | Gender (M/F) | First name | Last name | Date of birth/age | Alive (Y/N) | Date of death/ age | Type of cancer/tumour/polyps diagnosed? | Age at diagnosis | Hospital where treated |
| Your mother's brothers and sisters |  |  |  |  |  |  |  |  |  |
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| Your cousins on your mother’s side(Please use arrows to show who their parents are) |  |  |  |  |  |  |  |  |  |
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| Your father’s brothers and sisters |  |  |  |  |  |  |  |  |  |
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| Your cousins on your father’s side(Please use arrows to show who their parents are) |  |  |  |  |  |  |  |  |  |
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| Family cancer history (please list all your other relatives not previously listed that have had cancer) |
| Relationship to you | Gender (M/F) | First name | Last name | Date of birth/age | Alive (Y/N) | Date of death/age | Type of cancer/tumour/polyps diagnosed? | Age at diagnosis | Hospital where treated |
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| **Privacy information**  |
| **Collection of information:** We collect your personal information so that we can provide you with treatment and advice. Test results and further information collected while you are being treated are kept with your medical record. We only collect information that is relevant and necessary for your treatment and to manage the health service. |
| **Use and disclosure:** We will use or disclose your information for purposes directly related to your treatment, and in ways that you would reasonably expect for your ongoing care. This may include the transfer of relevant information to your nominated GP, to another treating health service or hospital, to a specialist for a referral, for pathology tests, X-rays and so on. |
| I understand and consent to the above  | Signature: | Date: |
| I do not consent to the above or I require further information | Signature: | Date: |

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| Please send this form to: |
| Please email to *<insert name of clinical genetic service>* on (02) *<phone>* or *<email>*ORReturn in the reply paid envelope provided or post to *<insert postal address here>.* Once this form is returned we will contact you to make an appointment. |

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