



Hereditary Cancer Program
2279 45th Street
Sacramento, CA 95817
Phone: (916) 734-5959, option 7
Fax: (916) 457-4531

www.ucdmc.ucdavis.edu/cancer/specialties/genetic

Name: _____

Appointment: _____

CHECK IN: 2nd floor, North building, UCD Comprehensive Cancer Center

Dear Hereditary Cancer Program Patient:

You have been referred to our clinic due to cancers or other clinical findings that may suggest a hereditary cancer condition in you or your family. Enclosed is a family history form. We appreciate your effort in gathering this information and providing it to us before the appointment if possible. It will help us determine whether genetic testing is recommended, and which tests we should consider.

If any family members have had genetic testing, please also provide us with a copy of their laboratory reports showing the test results.

As with all medical records, the information you provide is kept strictly confidential. We do not contact patients' relatives without prior permission.

Please return the completed family history form to our office before your appointment, using the fax number or mailing address above. A fax cover sheet is included for your convenience. Unfortunately, we do not have a way for you to securely submit the form online at this time. If necessary, please bring the filled-out form to your appointment.

Please see our website for more information about what to expect at your appointment:

www.ucdmc.ucdavis.edu/cancer/specialties/genetic

Thank you for your time and effort in gathering this information. We look forward to meeting with you. Please call us at 916-734-5959, option 7 if you have any questions.

Sincerely yours,

Hereditary Cancer Program
UC Davis Comprehensive Cancer Center

Pre-Visit Family History Form
 Instructions and Example

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Example

Ancestry or Ethnicity:
Japanese, mixed European

	Your Grandfather	Your Grandmother	
Current Age (or age at death)	<u>d. mid 80s?</u>	<u>d. 91</u>	
Cancer type	<u>N/A</u>	<u>breast</u>	
Age at diagnosis	<u>N/A</u>	<u>55</u>	

	Your Aunt/Uncle	Your Aunt/Uncle	Your Aunt/Uncle	Your Father
Current Age (or age at death)	<u>60</u>	<u>54</u>	<u>58</u>	<u>56</u>
Cancer type	<u>lung</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>
Age at diagnosis	<u>54</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>

	Your Paternal Cousins	
	With Cancer	Without Cancer
Current Age (or age at death)	<u>15 (M)</u>	<u>25 (F)</u>
Cancer type	<u>leukemia</u>	<u>brain</u>
Age at diagnosis	<u>13</u>	<u>18</u>

	Total #	<u>5</u>
	Gender	<u>2M, 3F</u>
	Age Range	<u>20-38</u>

Instructions

- Please provide information on ALL family members on both sides, even if they have not had cancer.
- Write “?” for any unknown family information. Please try to estimate ages of death or diagnosis if known (e.g., d.70s or 80s).
- Circle the appropriate relative name (e.g., aunt or uncle).
- If a relative is deceased, mark the age at death (e.g., d.80).
- Divide the sections for Your Cousins and Your Nieces/Nephews into TWO groups: **With Cancer** and **Without Cancer**.
 - **With Cancer:** List the current age (or age at death), gender (M= male, F=female and O=other), cancer type, and age at diagnosis for each person individually. If possible, please note the parent of these cousins in the “additional notes” section.
 - **Without Cancer:** List the total number of family members (e.g., 5), add up the number of family members by gender (e.g., 2M, 3F), and list the age range for these family members (e.g., 20-38).
- Copy this form or use the back if you need more space.

Please mail or fax us the completed form before your appointment if possible. Otherwise, please bring it to your appointment. Unfortunately, we do not have a secure method for online submission at this time.

Family History Form

Patient Name: _____

Visit Date: _____

Ancestry or Ethnicity:

Ancestry or Ethnicity:

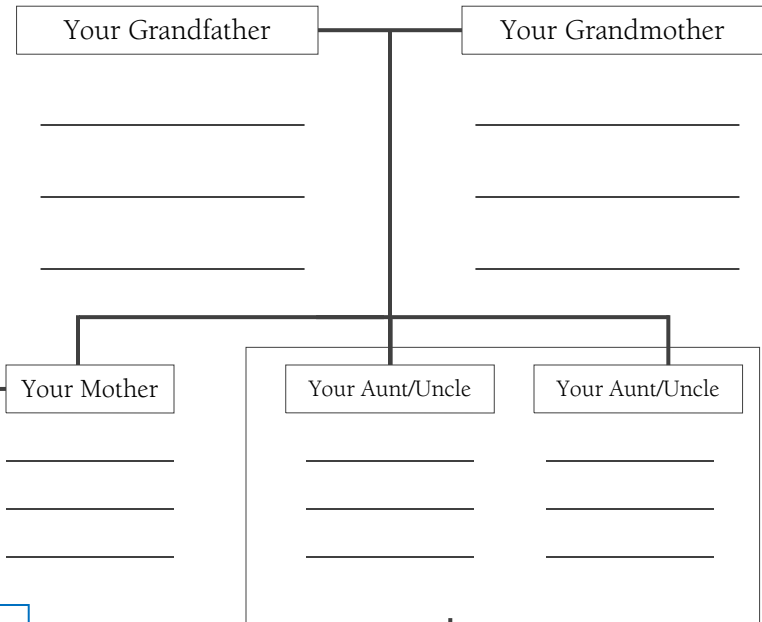
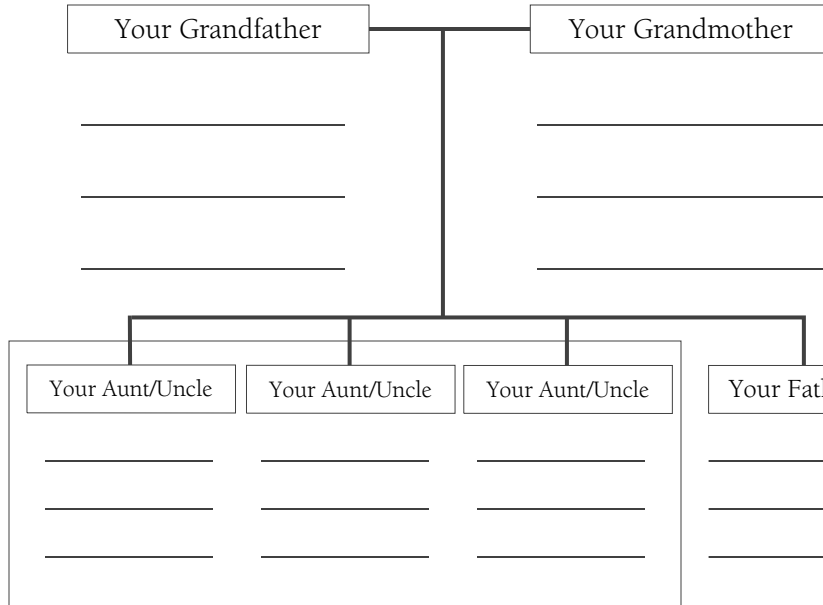
FATHER'S FAMILY

MOTHER'S FAMILY

Current Age
(or age at death)

Cancer type

Age at diagnosis



YOU

Current Age
(or age at death)

Cancer type

Age at diagnosis

Your Cousins

With Cancer	Without Cancer	Total #
_____	_____	_____
_____	_____	Gender _____
_____	_____	Age Range _____

Current Age
(or age at death)

Cancer type

Age at diagnosis

Your Cousins

With Cancer	Without Cancer	Total #
_____	_____	_____
_____	_____	Gender _____
_____	_____	Age Range _____

Current Age
(or age at death)

Cancer type

Age at diagnosis

YOU

Current Age _____

Cancer type _____

Age at diagnosis _____

Your Sister/Brother	Your Sister/Brother	Your Sister/Brother	Your Sister/Brother
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Children

Son or Daughter	Son or Daughter	Son or Daughter
_____	_____	_____
_____	_____	_____
_____	_____	_____
Son or Daughter	Son or Daughter	Son or Daughter
_____	_____	_____
_____	_____	_____
_____	_____	_____

Your Nieces/Nephews

With Cancer	Without Cancer
_____	_____
_____	_____
_____	_____
Total #	_____
Gender	_____
Age Range	_____

Current Age (or age at death) _____

Cancer type _____

Age at diagnosis _____

Current Age (or age at death) _____

Cancer type _____

Age at diagnosis _____

Additional Questions:

Do you have any known Ashkenazi Jewish ancestry? Yes / No

Are your parents closely related, such as first cousins? Yes / No

Have you or any of your relatives had 10 or more colon polyps found on colonoscopy? Yes / No

- if yes, please describe relatives and estimate number of polyps below.

Additional Notes

Fax Cover Sheet

Pre-Visit Family History Form

Patient Name: _____

Date of Birth: _____

Visit Date: _____

To: UC Davis Hereditary Cancer Program

Fax Number: (916) 457-4531

Number of pages, including this page, sent: _____

Warning: CONFIDENTIAL PATIENT INFORMATION FOR THE LISTED RECIPIENT ONLY. IF YOU RECEIVE THIS TRANSMISSION IN ERROR, PLEASE NOTIFY THE UCDCM COMPLIANCE OFFICE IMMEDIATELY BY CALLING: (916) 734-8808 TO ARRANGE FOR THE RETURN OF THESE DOCUMENTS.