

**FAMILY HISTORY QUESTIONNAIRE**  
(Please Print)

Your Name: \_\_\_\_\_

Date of Birth (D/M/Y): \_\_\_\_\_

Telephone (best number to reach you at): \_\_\_\_\_

May we leave a voice mail message at the above number?: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

**Genetic Testing:** Have you or any relatives had genetic testing?                      NO                      YES

If yes, please provide full name of relative: \_\_\_\_\_

Date of Birth (D/M/Y, if known): \_\_\_\_\_

Relationship to you (i.e. self, mother, father's sister): \_\_\_\_\_

Name/city of genetics clinic where you or your relative was tested: \_\_\_\_\_

Result (if known): \_\_\_\_\_

**Instructions:**

1. Please fill out the following questionnaire to the best of your ability.
2. If you were adopted please note that the information we need is about your biological family only.
3. If you don't know an answer, write "Don't Know" or "DK" in the space for the answer.
4. If necessary, please add a page with the additional information.
5. Please make a photocopy of this document for your records.

**If you are need to reschedule or cancel your appointment,  
please provide at least 48 hours notice.**

**If you have questions, please call 905-521-2100 x64636**

**Return this form in the enclosed envelope or by fax to 905-575-6379**

**Please tell us about yourself:**

Have you had cancer?	YES	NO	If yes, what type?	At what age?
Have you had bowel polyps removed?	YES	NO	If yes, how many?	At what age(s)?

**Please tell us about your brothers, sisters and children:**

Number of daughters:			
Number of sons:			
Number of full brothers:			
Number of full sisters:			
Number of half brothers:		Same mother or same father?	
Number of half sisters:		Same mother or same father?	

**Please tell us about the history of cancer in your children, brothers and sisters (if applicable)**

Relation to you	Full name (maiden name in brackets)	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Type of Cancer	Age when diagnosed
Eg. Sister	Pat (Smith) Doe			Ovary	46

**Please tell us about your mother:**

Your Mother's Full name (maiden name in brackets)	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Did your mother have cancer? (Please circle)	If yes, what type of cancer did she have?	How old was she when she was diagnosed?	How many siblings does your Mother have? (indicate with a number)
			YES / NO			___ brothers ___ sisters

**List any family members on your mother's side who have had cancer:**

Relation to you (eg. aunt)	Full name (maiden name in brackets)	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Type of Cancer	Age when diagnosed

**Please tell us about your father:**

Your Father's Full name	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Did your father have cancer? (Please circle)	If yes, what type of cancer did your father have?	How old was he when he was diagnosed?	How many siblings does your Father have? (indicate with a number)
			YES / NO			___ brothers ___ sisters

**List any family members on your father's side who have had cancer:**

Relation to you	Full name (maiden name in brackets)	Date of birth or current age (D/M/Y)	Date of Death or age at death (D/M/Y)	Type of Cancer	Age when diagnosed