

# Family History Questionnaire

**Indiana Familial Cancer Clinic  
Medical and Molecular Genetics Department  
Indiana University Health Physicians**

## Instructions

- When filling out the form, please complete both sides
- Please include all biological (blood) relatives whether or not they have been diagnosed with polyps and/or cancer. If you do not have exact dates or ages, please estimate.
- If there is not enough space for all relatives to be listed, please list the additional relatives on a separate sheet of paper and indicate how the individual(s) is related to you.
- You may need to speak with other family members to increase the accuracy of the information on this form. However, we understand that sometimes information is just not available to you.
- If you have any questions about completing this form, please contact us at 317-944-3966.
- A return envelope has been included for you to use in returning the completed form to us.

## Section A: General Information

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

Diagnosed with polyps, tumor and/or cancer?      Yes / No

If polyps: type, location and number of polyps

Date and/or age diagnosed:

If tumor or cancer:

Date and/or age diagnosed:

Where were you treated?

Treatment received:

## Section B: Your Parents

Name First and Last	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Your Mother		Yes / No	Yes / No
Your Father		Yes / No	Yes / No

## Section C: Your Children

Please list in order of birth

Name First and Last	Name of other parent	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Child #1		M / F		Yes / No	Yes / No
Child #2		M / F		Yes / No	Yes / No
Child #3		M / F		Yes / No	Yes / No
Child #4		M / F		Yes / No	Yes / No

**Section D: Your Brothers and Sisters:**

Please list in order of birth

Name First and Last	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Sibling #1	M / F		Yes / No	Yes / No
Sibling #2	M / F		Yes / No	Yes / No
Sibling #3	M / F		Yes / No	Yes / No
Sibling #4	M / F		Yes / No	Yes / No
Sibling #5	M / F		Yes / No	Yes / No

Are any of your siblings half-siblings to you, i.e. you share one parent only? Please write their names here and indicate whether you share the same mother or father.

## Section E: Your Nieces and Nephews

Sibling's Name (or corresponding number from prior page)	His / Her children Name; Date of birth or Age	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Sibling	1.  2.  3.	Yes / No  Yes / No  Yes / No	Yes / No  Yes / No  Yes / No
Sibling	1.  2.  3.	Yes / No  Yes / No  Yes / No	Yes / No  Yes / No  Yes / No
Sibling	1.  2.  3.	Yes / No  Yes / No  Yes / No	Yes / No  Yes / No  Yes / No
Sibling	1.  2.  3.	Yes / No  Yes / No  Yes / No	Yes / No  Yes / No  Yes / No
Sibling	1.  2.  3.	Yes / No  Yes / No  Yes / No	Yes / No  Yes / No  Yes / No

## Section F: Your Mother's Family

### *Your Mother's Parents*

Name First and Last	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Your Mother's Mother		Yes / No	Yes / No
Her maiden name: Her Country of origin/Ethnic background, i.e.: German, Japanese:			
Your Mother's Father		Yes / No	Yes / No
His Country of origin/Ethnic background, i.e.: German, Japanese:			

### *Your Mother's Brothers and Sisters (your maternal aunts and uncles)*

Name First and Last	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Sibling #1	M / F		Yes / No	Yes / No
Sibling #2	M / F		Yes / No	Yes / No
Sibling #3	M / F		Yes / No	Yes / No
Sibling #4	M / F		Yes / No	Yes / No

Are any of your mother's siblings half-siblings to her, i.e. they share one parent only? Please write their names here and indicate whether they share the same mother or father.

## Section G: Your Father's Family

### *Your Father's Parents*

Name First and Last	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Your Father's Mother		Yes / No	Yes / No
Her maiden name: Her Country of origin/Ethnic background, i.e.: German, Japanese:			
Your Father's Father		Yes / No	Yes / No
His Country of origin/Ethnic background, i.e.: German, Japanese:			

### *Your Father's Brothers and Sisters (your paternal aunts and uncles)*

Name First and Last	Sex	Date of Birth	Deceased? If yes, 1. Date and/or age at death 2. Cause of Death	Diagnosed with polyps, tumor and/or cancer? If yes, 1. Location, number of polyps 2. Type of cancer 3. Age at diagnosis (approximate if uncertain) 4. Treatment
Sibling #1	M / F		Yes / No	Yes / No
Sibling #2	M / F		Yes / No	Yes / No
Sibling #3	M / F		Yes / No	Yes / No
Sibling #4	M / F		Yes / No	Yes / No

Are any of your father's siblings half-siblings to him, i.e. they share one parent only? Please write their names here and indicate whether they share the same mother or father.

**Section H:**

Are there any first cousins (children of your aunts/uncles) diagnosed with polyps, tumor and/or cancer?

If so, please write their names here and indicate how they are related to you; please include type of polyps, their location, number and/or type of cancer, age at diagnosis and any other details that are available.

Are there other more distantly-related family members diagnosed with polyps, tumor and/or cancer?

If so, please write their names here (if needed, feel free to use back side of paper) and indicate how they are related to you; please include as many details as possible.

Has any family member undergone genetic testing for cancer susceptibility (i.e.: FAP/APC, MYH, BRCA1/BRCA2, HNPCC/MLH1/MSH2)?

If so, please write their name(s) here and indicate the genetic test performed and the result.

Please explain why you are interested in an appointment in this clinic. Are there any specific questions you have?

Thank you for taking the time to complete this form.