Sláinte Leanaí Éireann
ag Cromghlinn
Children's Health Ireland
at Crumlin

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PRIVATE AND CONFIDENITAL

Department of Clinical Genetics

Family History Questionnaire

You have been referred to the Cancer Genetic Service because of a history of cancer in you and/or your family. Please complete this questionnaire which will help us to assess whether or not your family history places you at an increased risk of cancer and whether increased surveillance and/or genetic testing would be recommended.

Please attempt to complete as many sections as possible. The more details you can provide, the more accurate we can be in our assessment. It is important to include those family members (alive and deceased) **who have had**, as well as those **who have not had cancer**, as this will have a bearing on your overall cancer risk**. If any member of your family has attended genetic services here or elsewhere please give their details. Please also let us know details of any family member already on our waiting list.** (Use additional paper, if required, for further relevant information)

If another copy is required please download a copy from our website: https://www.olchc.ie/services/departments-a-z/department-of-clinical-genetics/information-leaflets-forms/

Please complete all four pages and return the questionnaire within 2 weeks. We will not be able to offer an assessment of your cancer risk, or process your referral, until we have received your completed questionnaire.

If you have any queries or difficulties in completing the questionnaire, please do not hesitate to contact us at the above number. If you are unable to complete all the sections, please return the form anyway.

Name:		**GP Name:**	
Preferred pronoun and/or Title:		**GP Address:**	
Date of Birth:			
Address:		**Eircode:**	
		GP Telephone:	
Eircode:			
Telephone Number:			
Email:			

For office use only:
Date FHQ received into Department of Clinical Genetics:

Family Ref number PED:

Please complete the form below, giving as much information as possible about your close (blood) relatives, **including those who have NOT had cancer.** If there is any information you do not know, perhaps someone in your family will be able to help you, otherwise leave that box empty. All the information you give will be held in confidence in the Department of Clinical Genetics

THE INDIVIDUALS OUTLINED BELOW WILL NOT BE CONTACTED DIRECTLY, VALIDATION OF INFORMATION PROVIDED WILL BE IN ACCORDANCE WITH GDPR*

Relative	**Name** (including maiden and previous names) **and Last known address**	**Sex registered at birth**	**Date of Birth**	**Is this person still alive Y/N**	**If they are dead, their Date of Death**	**Type of cancer**		
						Which part of the body was affected by cancer	Age when cancer was found	Hospital where Treated (and name of consultant if known)
Self								
Your Children								
Your Mother								
Your Father								
Your Brothers (full or half – if half, which biological parent you share)								
Your Sisters (full or half – if half, which biological parent you share)								

**The Department of Clinical Genetics follows the Children's Health Ireland Privacy Statement. In addition to collecting personal and special category data for you or your child, we also request personal and special category data regarding your family members. The purpose of gathering this family information is to facilitate accurate genetic risk assessment for you and your family. This family history information is stored in the family genetics chart and/or in the Genetics patient information system.*

Relative	Name (including maiden and previous names) and Last known address	Sex registered at birth	Date of Birth	Is this person still alive Y/N	If they are dead, their Date of Death	Type of cancer		
						Which part of the body was affected	Age when cancer was found	Hospital where Treated (and name of consultant if known)
Your mother's mother								
Your mother's father								
Your mother's brothers /sisters								
Your father's mother								
Your father's father								
Your father's brothers /sisters								
Additional relatives diagnosed <u>with</u> cancer**								

****If any other relatives have had cancer, please include details on a separate sheet of paper stating clearly whether they are related to you though your mother or father (e.g. father's mother's sister)**

What are your main questions which you would like to discuss with the Cancer Genetics Team?

_____

_____

_____

Have you or any family member been seen by a Genetics department in the past? YES ☐ NO ☐ If yes, please provide further details and if available enclose a copy of their genetic report			
Name of relative that was seen by genetics		Their date of birth:	
Genetic service or hospital where they were tested:		Their relationship to you (e.g. sister/mother)	
When (date) they were seen:		Their family reference number (if known):	

Have/had you received any cancer surveillance (screening)?

Mammography	☐ Yes	☐ No	If yes, how often	Last date performed
MRI Breast	☐ Yes	☐ No	If yes, how often	Last date performed
Colonoscopy	☐ Yes	☐ No	If yes, how often	Last date performed
Other (please state) _____	☐ Yes	☐ No	If yes, how often	Last date performed

Lifestyle Factors (please complete as this information will help us better assess your cancer risk)

Current Height: _____ **Current Weight:** _____

Have you ever smoked tobacco? YES, Currently ☐ YES, Previously ☐ NO, Never ☐

How much alcohol do you drink in the average week? _____

What is your ethnicity? (Some types of genetic cancer are slightly more common based on ancestry) _____

Is there any Jewish ancestry in your family? ☐ YES ☐ NO If yes circle, mother's side or father's side

Is there any Polish ancestry in your family? ☐ YES ☐ NO If yes circle, mother's side or father's side

Are you and your partner (or your parents) blood related, for example, cousins? YES ☐ NO ☐
If yes please state who and how they are related_____

Age of first menstrual period: _____ **Age at menopause, if applicable:** _____

Did/Do you use the oral contraceptive pill? YES in the last 2 years ☐ YES over 2 years ago ☐ NO ☐
If YES for how long _____

Did/Do you use HRT? YES currently ☐ YES in the past ☐ NO ☐
If YES, for how long _____ Type of HRT_____

What Happens Next?

Our cancer team of genetic counsellors and consultants will assess the information you provided to see if your personal risk of developing cancer in the future is increased. We may contact you if we need further information. Once we have reviewed this Family History Questionnaire one of the following may occur:

- We may write to you with surveillance advice but not offer an appointment
- We may advise that your relative with cancer is seen by genetic services
- We may offer you a telephone or video appointment
- We may offer you a face to face appointment in one of our clinics

Thank you for completing this questionnaire.