METHODIST ESTABROOK CANCER CENTER
8303 Dodge Street
Omaha, NE

Family Cancer History Questionnaire

Please complete the following to the best of your ability.

Today's Date: ________________________

Your Name						
Street Address						
City, State, ZIP						
Home Phone Number			**Work Phone Number**			
Date of Birth						
Race/Ethnic Origin *(Please circle your answer)*	African-American	Ashkenazi Jew	Asian-American	Caucasian	Hispanic	Other

Personal History

Have you ever been diagnosed with cancer?	Yes	No
If yes, what type and location of cancer?		
If yes, what was your age at diagnosis (or the year of diagnosis)?		
Any other significant diseases?		

Your Biological Children and their Parent:

Full Name *First, Middle, Last, (Maiden)*	**Date of Birth *or* Age**	**Alive or Dead**	**Date of Death**	**Ever had Cancer?**	**Type and Location of Cancer**	**Age and Year of Diagnosis**	**Other Significant Diseases**
Spouse		o Alive o Dead		o Yes o No o Unsure			
1. Child o Male o Female		o Alive o Dead		o Yes o No o Unsure			
2. Child o Male o Female		o Alive o Dead		o Yes o No o Unsure			
3. Child o Male o Female		o Alive o Dead		o Yes o No o Unsure			
4. Child o Male o Female		o Alive o Dead		o Yes o No o Unsure			
5. Child o Male o Female		o Alive o Dead		o Yes o No o Unsure			

<u>Your Parents and Siblings:</u>

Your Biological Parents Full Name First, Middle, Last, (Maiden)	**Date of Birth *or* Age**	**Alive Or Dead**	**Date of Death**	**Ever had Cancer?**	**Type and Location of Cancer**	**Age and Year of Diagnosis**	**Other Significant Diseases**
Father		o Alive o Dead		o Yes o No o Unsure			
Mother		o Alive o Dead		o Yes o No o Unsure			

Your Brothers & Sisters Full Name	**Date of Birth *or* Age**	**Alive or Dead**	**Date of Death**	**Ever had Cancer?**	**Type and Location of Cancer**	**Age and Year of Diagnosis**	**Other Diseases**	**His/Her Children** *(Name; Age; Health)*
1. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.
2. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.
3. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.

4. ○ M ○ F		○ Alive ○ Dead	○ Yes ○ No ○ Unsure				1. 2. 3. 4.
5. ○ M ○ F		○ Alive ○ Dead	○ Yes ○ No ○ Unsure				1. 2. 3. 4.

<u>Your Father's Parents and Siblings:</u>

Your Father's Parents & Country of Origin Full Name First, Middle, Last, (Maiden)	**Date of Birth *or* Age**	**Alive or Dead**	**Date of Death**	**Ever had Cancer?**	**Type and Location of Cancer**	**Age and Year of Diagnosis**	**Other Significant Diseases**
Your Father's Father Country of Origin		○ Alive ○ Dead		○ Yes ○ No ○ Unsure			
Your Father's Mother Country of Origin		○ Alive ○ Dead		○ Yes ○ No ○ Unsure			

Father's Brothers & Sisters Full Name	**Date of Birth *or* Age**	**Alive or Dead**	**Date of Death**	**Ever had cancer?**	**Type and Location of Cancer**	**Age and Year of Diagnosis**	**Other Diseases**	**His/Her Children** *(Name; Age; Health)*
1. ○ M ○ F		○ Alive ○ Dead		○ Yes ○ No ○ Unsure				1. 2. 3. 4.
2. ○ M ○ F		○ Alive ○ Dead		○ Yes ○ No ○ Unsure				1. 2. 3. 4.
3. ○ M ○ F		○ Alive ○ Dead		○ Yes ○ No ○ Unsure				1. 2. 3. 4.
4. ○ M ○ F		○ Alive ○ Dead		○ Yes ○ No ○ Unsure				1. 2. 3. 4.
5. ○ M ○ F		○ Alive ○ Dead		○ Yes ○ No ○ Unsure				1. 2. 3. 4.

<u>Your Mother's Parents and Siblings</u>:

Your Mother's Parents & Country of Origin Full Name First, Middle, Last, (Maiden)	Date of Birth *or* Age	Alive or Dead	Date of Death	Ever had Cancer?	Type and Location of Cancer	Age and Year of Diagnosis	Other Significant Diseases
Your Mother's Father Country of Origin		o Alive o Dead		o Yes o No o Unsure			
Your Mother's Mother Country of Origin		o Alive o Dead		o Yes o No o Unsure			

Mother's Brothers & Sisters Full Name	Date of Birth *or* Age	Alive Or Dead	Date of Death	Ever Had cancer?	Type and Location of Cancer	Age of diagnosis and year	Other Diseases	His/Her Children *(Name; Age; Health)*
1. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.
2. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.
3. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.
4. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.
5. o M o F		o Alive o Dead		o Yes o No o Unsure				1. 2. 3. 4.

Anyone in Family Diagnosed With Cancer Not Previously Listed:

Full Name First, Middle, Last, (Maiden)	Relation to You	Date of Birth *or* Age	Alive or Dead	Date of Death	Type and Location of Cancer	Age and Year of Diagnosis	Other Significant Diseases
1. o M o F							
2. o M o F							
3. o M o F							
4. o M o F							

Questions You Would Like Addressed at Your Clinic Visit:

Name of your Physician	
Street Address	
City, State, ZIP	
Phone Number	

Referred to Cancer Prevention & Hereditary Cancer Risk Program by: *(Please circle your answer)*				
Community Program	A Friend/ Family Member	Methodist Breast Center	Physician Referral	Other

For more information about the Cancer Prevention & Hereditary Cancer Risk Program, call (402) 354-5276.