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| Breast Imaging Unit / FH Service  Level C |
| Princess Anne Hospital  Southampton  SO16 5YA |
| Tel: 023 8120 8709 |
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**FAMILY HISTORY ENQUIRY FORM**

Please ensure this questionnaire is retuned before your appointment is due. This information is required for the appointment to be able to go ahead.

**Date:**

**This form MUST be accompanied by a referral from a healthcare professional.**

Please complete this form, giving as much information as possible about your immediate (blood) relatives. If there is any information you do not know, leave that box empty. All the information you give will be held in confidence in the Breast Unit Department.

* Please let us know the details of all family members, even if they have not had cancer. This is important in assessing your cancer risk.
* If you do not know the exact dates of birth and/or death or where the person was treated is not known, then please put approximate dates and ages and where in the country the person lived.
* Some names can be used for both females and males, or are unusual. Please indicate male or female for these people.

**Please return your questionnaire as soon as possible in order for an accurate risk assessment to be made. If you are unable to complete all the sections, please still return the form.**

**Name ……………………………………… Date of birth ………………………………….**

**Previous surnames………………………… GP Name………………………………………**

**Address ……………………………………. GP Address……………………………………**

**……………………………………………… …………………………………………………**

**……………………………………………… …………………………………………………**

**Tel No: ……………………………………… Email:**……………………………………………

We may contact you by phone if we need any further details. In order to respect patient confidentiality, we will not disclose where we are calling from to anyone apart from yourself, without your permission:

* I am happy for you to disclose where you are calling from, should someone other than myself answer the phone YES / NO

* I would prefer to receive a letter from you, asking me to call the department, should you need any further details.

If you know of anyone else in your family who has been seen by another Genetics Service or referred to Wessex Clinical Genetics Service, it would be helpful to provide some details here:

Name: ................................................................................ Date of birth:.........................................................................

Genetics Service where seen: ...............................................................................................................................................

Other information if known………………………………………………………………………………………………...

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Relative | | **Name**  (including maiden and any previous names) | Date of  Birth | | Alive  Y/N | | Date of  death | | If you/your relatives suffered from cancer …….  Where cancer Age when cancer Hospitals where treated  occurred found (+name of specialist if known) | | | | | |
| **You** | |  |  | |  | |  | |  | |  | |  | |
| Your  Own  Children | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Your  sisters  full or half  (if half, please state through mother or father) | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Your  brothers  full or half (if half, please state through mother or father) | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Your  mother | |  |  | |  | |  | |  | |  | |  | |
| Your  father | |  |  | |  | |  | |  | |  | |  | |
| Relative | **Name**  (including maiden and any previous names) | | | Date of  Birth | | Alive  Y/N | | Date of  death | | If your relatives suffered from cancer …….  Where cancer Age when cancer Hospitals where treated  occurred found (+name of specialist if known) | | | | |
| Your mother’s mother |  | | |  | |  | |  | |  | |  | |  |
| Your  mother’s  father |  | | |  | |  | |  | |  | |  | |  |
| Your father’s  mother |  | | |  | |  | |  | |  | |  | |  |
| Your  father’s  father |  | | |  | |  | |  | |  | |  | |  |
| Your  mother’s  brothers and sisters | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Your father’s brothers and sisters | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other relatives affected with cancer | ***Please state how they are related to you***  E.g. mother’s father’s mother.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | \_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Some types of genetic cancer are slightly more common in Jewish families. Are you or any of your immediate family Jewish? Yes No

**Please complete this section if you are female and have a family or personal history of breast or ovarian cancer**

1. At what age did your periods start? …………………………………………..
2. At what age did you go through menopause? ………………(if appropriate)
3. Are you taking the contraceptive pill? Yes No
4. For how many years of your life have you been on the contraceptive pill (if at all)? ……………
5. Are you taking Hormone Replacement Therapy (HRT)? Yes No If yes for how long?…………
6. Have you ever had any problems with your breasts other than cancer? If so please describe the nature of this, including dates, hospital and names of specialists seen.

**Please feel free to use a separate sheet of paper if you wish.**

If you have had cancer, please give details including dates, hospital and names of specialists seen and any medication.

Please feel free to use a separate sheet of paper if you wish.

Have you had/do you have any major illnesses (excluding cancer) or surgery? Please give details including dates, hospital and names of specialists seen and any medication.

Please feel free to use a separate sheet of paper if you wish.

What are your **main questions** that you would like to discuss with the genetics service?

Please feel free to use a separate sheet of paper if you wish.