



## Pre-Appointment Cancer Genetics Questionnaire

Please tell us about your health and your family's health. Knowing this helps the Genetics team tell you about risk for cancer, what genetic tests might help, and how you and your family can be as healthy as possible.

Please email the completed form to: [cancergenetics@vcuhealth.org](mailto:cancergenetics@vcuhealth.org)

You may also fax the completed form to **(804) 827-4100** or mail it to:

Attn: Cancer Genetic Counselor  
 Department of Human and Molecular Genetics  
 Virginia Commonwealth University  
 1101 E. Marshall St.; Richmond, Virginia 23298-0033

### I. General Information about You

1. Name: \_\_\_\_\_
2. Date of Birth: \_\_\_\_\_
3. Referring Doctor: \_\_\_\_\_
4. What are your goals for your genetic counseling appointment? \_\_\_\_\_
5. Has anyone in your family had genetic testing?
  - \_\_\_ No
  - \_\_\_ Yes; please describe: \_\_\_\_\_  
*If possible, please bring a copy of the genetic test results with you for your genetic counseling appointment, or email them to cancergenetics@vcuhealth.org*

### II. Your Health History and Other Risk Factors

6. Have you had cancer?
  - \_\_\_ No
  - \_\_\_ Yes; Type of cancer: \_\_\_\_\_  
 Age when diagnosed: \_\_\_\_\_  
 Treatment: \_\_\_\_\_
7. Have you ever had a bone marrow transplant?
  - \_\_\_ No
  - \_\_\_ Yes
8. Have you had a blood transfusion in the last two weeks?
  - \_\_\_ No
  - \_\_\_ Yes
9. What surgeries have you had? \_\_\_\_\_

10. What medications do you take? \_\_\_\_\_
11. What allergies do you have? \_\_\_\_\_
12. How much do you weigh? \_\_\_\_\_ pounds
13. How tall are you? \_\_\_\_\_ feet \_\_\_\_\_ inches
14. In a typical week, about how many minutes of exercise do you get? \_\_\_\_\_ minutes
15. How many cups (1 cup = 2 servings) of fruits and vegetables do you eat on a typical day?
- \_\_\_ None
  - \_\_\_ Fewer than 2 ½ cups
  - \_\_\_ At least 2 ½ cups

16. Have you smoked at least 100 cigarettes in your life?

\_\_\_ No \_\_\_ Yes; For how long? \_\_\_ years; How many packs per day? \_\_\_ Currently smoke? \_\_\_ No \_\_\_ Yes

17. On a typical day about how many alcoholic beverages do you drink?

- \_\_\_ I never drink alcoholic beverages
- \_\_\_ Less than one
- \_\_\_ One per day
- \_\_\_ Two per day
- \_\_\_ More than two per day

**Women Only**

18. When did you have your first period? \_\_\_\_\_ years old

19. Have you had children?

- \_\_\_ No
- \_\_\_ Yes

How old were you when you had your first child? \_\_\_\_\_ years old

20. Have you had your uterus/womb or ovaries removed?

- \_\_\_ No
- \_\_\_ Yes

How old were you? \_\_\_\_\_ years old

What was removed?

- \_\_\_ Uterus
- \_\_\_ One ovary
- \_\_\_ Both ovaries

21. Which one best describes you?

- Pre-menopausal  
 Peri-menopausal  
 Post-menopausal: Approximate age at menopause? \_\_\_\_\_ years old  
 Unsure

22. Have you ever used oral contraceptives?

- No  
 Yes When did you start/stop? \_\_\_\_\_

23. Have you ever used hormone replacement therapy?

- No  
 Yes What medicine? \_\_\_\_\_  
 When did you start/stop? \_\_\_\_\_

24. How many breast biopsies have you had?

- None  
 1  
 More than 1

25. If you have had a breast biopsy, did any show "atypical hyperplasia"?

- Yes  
 No  
 Unsure

### III. Your Cancer Screening

"Screening" is a routine way to look for early signs of cancer when you are not having symptoms. This is different than a test that follows up on symptoms, such as a work-up of a breast lump.

	Have You Ever Had This Screening?		When Was Your Last Screening?
	No	Yes	
<b>Women and Men</b>			
Digital Rectal Exam	<input type="radio"/>	<input type="radio"/>	
Sigmoidoscopy	<input type="radio"/>	<input type="radio"/>	
Colonoscopy	<input type="radio"/>	<input type="radio"/>	
Barium Enema	<input type="radio"/>	<input type="radio"/>	
Fecal Occult Blood Test	<input type="radio"/>	<input type="radio"/>	
CT Colonography (Virtual Colonoscopy)	<input type="radio"/>	<input type="radio"/>	
Clinical Breast Exam	<input type="radio"/>	<input type="radio"/>	
Mammogram	<input type="radio"/>	<input type="radio"/>	
Breast MRI	<input type="radio"/>	<input type="radio"/>	
<b>Women Only</b>			
Pap Test	<input type="radio"/>	<input type="radio"/>	
Endometrial Biopsy	<input type="radio"/>	<input type="radio"/>	
Transvaginal Ultrasound	<input type="radio"/>	<input type="radio"/>	
CA-125 Measurement	<input type="radio"/>	<input type="radio"/>	
<b>Men Only</b>			
PSA Measurement	<input type="radio"/>	<input type="radio"/>	

