PENINSULA CLINICAL GENETICS SERVICE

Royal Devon & Exeter Hospital
(Heavitree)
Gladstone Road
EXETER EX1 2ED

Royal Cornwall Hospital
Treliske
TRURO
TR1 3LJ

Derriford Hospital
Derriford Road
PLYMOUTH
PL6 8DH

Family History Form (Cancer)

You have been referred to the Peninsula Clinical Genetics Service because of a personal and / or family history of cancer. Please complete this questionnaire to help us assess this for you. **If you have any queries or difficulties in completing the form please do not hesitate to contact us by email at rduh.pcgfamilyhistory@nhs.net or on 01392 405751.** Once we have received your questionnaire and confirmed any key information, we will contact you to arrange an appointment. **Please return this questionnaire as soon as possible. Thank you.**

Title:_____ Forenames:_____ Surname:_____ Pronouns (optional):_____

Name you prefer to be addressed by (optional):_____ Your date of birth: _____

Address: _____

_____ Postcode: _____

Telephone number (day): _____ (evening): _____

Email address: _____

Are you happy for us to contact you by telephone? YES / NO If you have an answer-phone are you happy for us to leave a message? YES / NO

GP Name: _____ GP Address: _____

Please note any additional information, such as donor conception, adoption, or anything else you would like us to understand about your family:

_____

_____

If a member of your family has been seen by Peninsula Clinical Genetics service, please note this on the form below.

If you know their Genetics reference number please add it here: _____

If they have been seen by a different Genetics service, please tell us which one, if you know.

Your immediate family history

	Name (including previous names)	Sex registered at birth	Gender How you identify	Date of Birth	Alive Y/N	Date of Death	Cancer diagnoses		
							Type(s) of cancer	Age at diagnosis	Hospital where treated
You									
Your parents									
Your children									
Your brothers / sisters / siblings (please state whether full or half – if half, state through which parent you are related)									

Your paternal family history: people related to you through your biological father

Your biological father	Name (including previous names)	Sex registered at birth	Gender How you identify	Date of Birth	Alive Y/N	Date of Death	Cancer diagnoses		
							Type (s) of cancer	Age at diagnosis	Hospital where treated
Your father's parents									
Your father's brothers / sisters / siblings (please state whether full or half – if half, state through which parent you are related)									
Any other relatives (cousins etc) with cancer Please state through which parent you are related.									

Your maternal family history: people related to you through your biological mother

Your biological mother	Name (including previous names)	Sex registered at birth	Gender How you identify	Date of Birth	Alive Y/N	Date of Death	Cancer diagnoses		
							Type(s) of cancer	Age at diagnosis	Hospital where treated
Your mother's parents									
Your mother's brothers / sisters / siblings (please state whether full or half – if half, state through which parent you are related)									
Any other relatives (cousins etc.) with cancer. Please state through which parent you are related.									

About you

Your occupation _____

Some conditions are more common in certain ethnic groups. What is your ethnicity? _____

Some types of genetic cancer are slightly more common in people with Jewish ancestry. Do you have Jewish heritage? YES / NO

Is there any other information that you think may be relevant?

_____

_____

_____

Do you have any particular questions that you would like us to address in clinic?

_____

_____

_____

Please complete this section only if you were assigned female at birth, and have a family history of BREAST or OVARIAN cancer.

- Are you taking the contraceptive pill? YES / NO If **Yes**, for how many years? _____
- Are you taking Hormone Replacement Therapy (HRT)? YES / NO If **Yes**, for how many years? _____
- Have you ever had a scan of your ovaries? YES / NO If **Yes**, when was your last one? _____
- Have you ever had a mammogram or breast MRI scan? YES / NO If **Yes**, when was your last one? _____
- Have you ever had any problems with your breast tissue? If so please describe nature including dates, hospital and names of specialists seen:

Thank you for completing this questionnaire.

For official use only Genetic number: ……..

Any significant Family History to confirm? Y / N …… …….

Date issued: …… Date returned: ……