Dynacare®
Genetics and Specialty Services

Cancer Medical and Family History Questionnaire

Patient Name: _____ DOB (mm/dd/yyyy): _____

Current gender identity: ☐ Male ☐ Female ☐ Non-binary ☐ Other ☐ Prefer not to say

Biological Sex Assigned at Birth: ☐ Male ☐ Female ☐ Other (specify) _____
☐ Prefer not to say

What pronouns do you prefer? ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other (specify) _____

Please indicate your preferred language of communication:
☐ English ☐ French ☐ English or French (bilingual) ☐ Mandarin ☐ Other: _____

Email address: _____ Telephone number: _____

Can we leave a message at this telephone number? ☐ Yes ☐ No

Personal Health Information

Please complete this questionnaire to the best of your ability. You will meet with a genetic counsellor and/or geneticist at your appointment. Information provided on your personal medical and family history will be used to provide a cancer risk assessment. This information will be important to determine your eligibility for genetic testing and recommendations for screening and/or prevention.

General Health Information

What is your height? _____ ☐ ft/in ☐ M What is your weight? _____ ☐ lbs ☐ kg

Have you ever had a bone marrow transplant? ☐ Yes ☐ No

If yes, was the bone marrow transplant your own? ☐ Yes ☐ No

Have you or will you be having a blood transfusion? ☐ Yes ☐ No

Do you have any health concern(s) other than cancer for which you are taking medication(s), seeing a specialist, or are followed by your family doctor? ☐ Yes ☐ No

If you answered yes to having health concern(s), please list your health concerns:

_____

_____

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Personal History Of Cancer/Tumors

Have you been diagnosed with cancer? ☐ Yes ☐ No

Type of Cancer	Age at diagnosis

Have you ever had a breast biopsy? ☐ Yes ☐ No

Have you ever been told you have atypical hyperplasia? ☐ Yes ☐ No ☐ Unknown

Have you ever been told you have lobular carcinoma in situ (LCIS)? ☐ Yes ☐ No

Female Health Information

Menarche

How old were you when you had your first period?
_____ years old

Menopausal Status

Have your periods stopped completely (post-menopausal)?
☐ Yes ☐ No ☐ Unknown

How old were you when your periods stopped completely? _____ years old

Oral Contraceptive Use

Have you ever taken any oral contraceptives (birth control pills)? ☐ Yes ☐ No ☐ Unknown

If you answered yes to oral contractive use, how many years did you take it for?
☐ Less than 1 year ☐ 1-4 years ☐ 5-9 years
☐ 10-14 years ☐ 15 or more years

Have you taken oral contraceptives in the last two years? ☐ Yes ☐ No

Hormone Replacement Therapy Use

Have you ever taken any hormone replacement therapy (HRT) for menopause? ☐ Yes ☐ No

If you answered yes to the use of HRT, how many years did you use HRT? (if less than one year, write 0)

_____

Have you used HRT in the last 5 years? ☐ Yes ☐ No

If you used HRT in the last 5 years, what type of HRT did you use?
☐ Oestrogen only ☐ Known combined therapy ☐ Other HRT ☐ Progesterone only ☐ Unknown

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Gynecological Conditions/Surgery

Have you ever been diagnosed with endometriosis?
☐ Yes ☐ No ☐ Unknown

Have you had your tubes tied (tubal ligation)?
☐ Yes ☐ No ☐ Unknown

Do you have both of your ovaries?
☐ Yes ☐ No ☐ Unknown

If your ovary/ovaries were removed, how old were you when your ovary/ovaries were removed?
_____ years old

Do you have both of your fallopian tubes?
☐ Yes ☐ No ☐ Unknown

How old were you when you had your fallopian tube(s) removed? _____ years old

Do you have your uterus?
☐ Yes ☐ No ☐ Unknown

If your uterus was removed, how old were you when your uterus was removed? _____ years old

Why did you have your ovaries and/or uterus removed (please provide details)?

_____

Why did you have your fallopian tube(s) removed (please provide details)?

_____

Pregnancy History

Do you have biological children? ☐ Yes ☐ No

If yes, how old were you when your first child was born? _____ years old

Cancer Medical and Family History Questionnaire

Cancer Screening

Breast Screening

Have you ever had a mammogram? ☐ Yes ☐ No

Have you ever been told that you have high breast density? ☐ Yes ☐ No ☐ Unknown

My last mammogram was (month/year): _____

I have a mammogram every _____

Have you ever had a breast MRI? ☐ Yes ☐ No

My last breast MRI was (month/year): _____

I have a breast MRI every _____

Prostate Screening

Have you ever had prostate cancer screening (PSA and/or digital rectal exam)? ☐ Yes ☐ No

My last prostate cancer screening exam was (month/year): _____

I have prostate cancer screening every _____

Have you ever had an abnormal PSA?
☐ Yes ☐ No

Have you ever had a prostate biopsy/biopsies?
☐ Yes ☐ No

What were the results of your prostate biopsy/ biopsies (please provide details)?

_____

_____

_____

_____

Skin Screening

Do you get regular skin exams? ☐ Yes ☐ No

If you answered yes to regular skin exams, why do you have them?

_____

_____

_____

_____

_____

_____

Do you have or have you had 50 or more moles/ nevi? ☐ Yes ☐ No

Have you/do you sunbathe, use a tanning bed, or are exposed to a significant amount of sun?
☐ Yes ☐ No

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Cancer Screening - Gastrointestinal Screening

Colonoscopy

Have you ever had a colonoscopy?
☐ Yes ☐ No ☐ Unknown

If you answered yes to having a colonoscopy:
My last colonoscopy was (month/year):

_____

I have a colonoscopy every _____

Reason for colonoscopy (please provide details):

_____

_____

Were there any polyps found on your colonoscopy/ colonoscopies?
☐ Yes ☐ No ☐ Unknown

If you answered yes to having polyps, how many colonic polyps have you had in total?

_____

_____

_____

Endoscopy

Have you ever had an endoscopy?
☐ Yes ☐ No ☐ Unknown

If you answered yes to having an endoscopy:
My last endoscopy was (month/year):

_____

I have an endoscopy every _____

Reason for endoscopy (please provide details):

_____

_____

_____

What were the results of your endoscopies (please provide details):

_____

_____

_____

_____

Lifestyle Information

Do you currently/have you previously smoke(d)?
☐ Yes, currently ☐ Yes, previously ☐ No

Currently, I smoke (enter #)____ cigarettes/day

Do you currently drink alcohol? ☐ Yes ☐ No

I drink (enter #) _____ of

☐ Glass of wine ☐ pint of beer/lager/cider
☐ bottle of beer ☐ shots of spirits

per ☐ Day ☐ Week ☐ Month

Are you aware of any cancer-causing exposures because of your job/the area where you live or lived (For example, asbestos)? ☐ Yes ☐ No ☐ Unknown

If yes, please describe the cancer-causing exposure:

_____

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Additional information you think is important for us to know:

_____

_____

_____

Family History Information

Are you adopted? ☐ Yes ☐ No

What is your ancestry? (please check all that apply)

☐ African ☐ Ashkenazi Jewish ☐ Asian
☐ Arab ☐ Acadian ☐ Caribbean
☐ European ☐ European (Eastern)
☐ French Canadian ☐ Hispanic
☐ Indigenous Canadian ☐ Pacific Islander
☐ Other (please specify):

_____

Do you have any Ashkenazi Jewish ancestry on either your biological mother and/or father's side of the family? ☐ Yes ☐ No ☐ Unknown

Are your parents consanguineous (related to each other by blood)? ☐ Yes ☐ No

Is there a known hereditary cancer syndrome in your family or a known mutation in your family?
☐ Yes ☐ No

The name of the hereditary cancer syndrome/gene in which there is a mutation is called

_____

(**Please provide a copy of the genetic test result or consult letter)

This mutation/hereditary cancer syndrome was found in my ☐ maternal ☐ paternal

☐ Mother ☐ Father ☐ Brother
☐ Sister ☐ Daughter ☐ Son
☐ Niece ☐ Nephew ☐ Grandchild
☐ Aunt ☐ Uncle ☐ Cousin
☐ Grandmother ☐ Grandfather

Please fill out your family history information to the best of your ability. Exact ages at cancer diagnosis are not required, estimates are sufficient. If you require additional space for your family history, please use the comment section below.

	Name of person	Living/Deceased	Cancer History	Age(s) at Diagnosis
Mother		☐ Living ☐ Deceased		
Father		☐ Living ☐ Deceased		
Maternal Grandmother		☐ Living ☐ Deceased		
Maternal Grandfather		☐ Living ☐ Deceased		

Family History Information Continued

Daughter/ Son	Half Sibling	Maternal / Paternal *for half siblings	Name of person	Living/ Deceased	Cancer History	Age(s) at Diagnosis
☐ Daughter ☐ Son	☐	☐ Maternal ☐ Paternal		☐ Living ☐ Deceased		
☐ Daughter ☐ Son	☐	☐ Maternal ☐ Paternal		☐ Living ☐ Deceased		
☐ Daughter ☐ Son	☐	☐ Maternal ☐ Paternal		☐ Living ☐ Deceased		
☐ Daughter ☐ Son	☐	☐ Maternal ☐ Paternal		☐ Living ☐ Deceased		
☐ Daughter ☐ Son	☐	☐ Maternal ☐ Paternal		☐ Living ☐ Deceased		
☐ Daughter ☐ Son	☐	☐ Maternal ☐ Paternal		☐ Living ☐ Deceased		

Maternal Aunt/Uncle	Name of person	Living/Deceased	Cancer History	Age(s) at Diagnosis
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		

Paternal Aunt/Uncle	Name of person	Living/Deceased	Cancer History	Age(s) at Diagnosis
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		
☐ Aunt ☐ Uncle		☐ Living ☐ Deceased		

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Family History Information Continued

Paternal Cousin's Name	Mother/Father's Name	Living/Deceased	Cancer History	Age(s) at Diagnosis
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Other Family member(s) (specify relationship)	Name of Person	Living/Deceased	Cancer History	Age(s) at Diagnosis
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		
		☐ Living ☐ Deceased		

Additional information you think is important for us to know: