COLUMBIA-PRESBYTERIAN COMPREHENSIVE BREAST

METROPOLITAN NEW YORK REGISTRY

FAMILY HISTORY SCREENING FORM

This form asks you about your family history of breast, ovarian and other cancers. The information you provide will help identify individuals from families believed to be at increased risk of developing a specific cancer(s). If your family history suggests an increased risk, your doctor will notify you and offer you participation in risk assessment, counseling and/or research programs at The Comprehensive Breast Center.

Your responses to the questionnaire will be kept completely confidential and will not affect the care you receive. If you have any questions or would like help in filling it out, please contact Karen Ruderman at (212)305-8856 or 1(800)557-8386 or Donna Russo (212)-305-0190 of the Cancer Genetics Program.

We thank you for your participation.

Please print the following information:

Last Name, First Name		
Street Address		
City, State, Zip		
Home Phone with Area Code		Is it OK to leave a message on the machine? Y N
Work Phone with Area Code		Is it OK to leave a message on the machine? Y N

Please return this completed form to YOUR PHYSICIAN or:

Columbia-Presbyterian Medical Center
Metropolitan New York Registry
630 West 168th Street, PH18-Room 200, New York, NY 10032
(212)305-8856 or (800)557-8386

Today's Date: ___/____/___

What is your birth date? ___/____/____ Age:____ Were you adopted? O Yes O No

Have you ever been diagnosed with cancer? O No O Yes….**What type of cancer (s)?**

(1) _____ Age at diagnosis ____

(2) _____ Age at diagnosis ____

(3) _____ Age at diagnosis ____

Have any of your male relatives been diagnosed with breast cancer? O Yes O No O Don't know

FAMILY HISTORY OF BREAST, OVARIAN, AND OTHER CANCERS

Please fill in the dots and corresponding information for family members with cancer only.

YOUR IMMEDIATE FAMILY:

	BREAST CANCER	Age @ Diag.	2nd Breast Cancer Age @ diag.	OVARIAN CANCER	Age @ Diag.	OTHER CANCER	OTHER CANCER* (Specify)	Age @ Diag.	Alive (A)/ Deceased(D)
example	O	*51*	Bilateral, 61	O		O	*colon cancer*	*72*	*A*
Your Mother	O			O		O			
Your Father	O			O		O			
Child 1	O			O		O			
Child 2	O			O		O			
Sister 1	O			O		O			
Sister 2	O			O		O			
Sister 3	O			O		O			
Brother 1	O			O		O			
Brother 2	O			O		O			
Brother 3	O			O		O			

MOTHER'S SIDE OF THE FAMILY: CHECK HERE IF NO KNOWN CANCER ON MOTHER'S SIDE

MATERNAL	BREAST CANCER	Age @ Diag.	2nd Breast Cancer age @ Diag.	OVARIAN CANCER	Age@ Diag.	OTHER CANCER	OTHER CANCER* (Specify)	Age @ Diag.	Alive (A)/ Deceased(D)
Grandmother	O			O		O			
Grandfather	O			O		O			
Aunt 1	O			O		O			
Aunt 2	O			O		O			
Aunt 3	O			O		O			
Uncle 1	O			O		O			
Uncle 2	O			O		O			
Uncle 3	O			O		O			
1st Cousin 1	O			O		O			
1st Cousin 2	O			O		O			
1st Cousin 3	O			O		O			
OTHER Maternal Relatives- Please specify relation (e.g. great-aunt, 2nd cousin)									
	O			O		O			
	O			O		O			
	O			O		O			

* Please see reference list of OTHER types of cancer on next page.

PLEASE GO TO NEXT PAGE

FATHER'S SIDE OF THE FAMILY: **CHECK HERE IF NO KNOWN CANCER ON FATHER'S SIDE**

PATERNAL	BREAST CANCER	Age @ Diag.	2nd Breast Cancer, Age @ diag.	OVARIAN CANCER	Age@ Diag.	OTHER CANCER	*OTHER CANCER (Specify)	Age @ Diag.	Alive (A)/ Deceased(D)
Grandmother	O			O		O			
Grandfather	O			O		O			
Aunt 1	O			O		O			
Aunt 2	O			O		O			
Aunt 3	O			O		O			
Uncle 1	O			O		O			
Uncle 2	O			O		O			
Uncle 3	O			O		O			
1st Cousin 1	O			O		O			
1st Cousin 2	O			O		O			
1st Cousin 3	O			O		O			
OTHER Paternal Relatives- Please specify relation (e.g. great-aunt, 2nd cousin)									
	O			O		O			
	O			O		O			
	O			O		O			

*Reference List of Types of Cancer

Bladder
Bone
Brain
Colon/Rectal
Kidney
Lung
Melanoma (Skin)
Pancreas
Prostate
Sarcoma
Stomach
Thyroid
Uterine (cervical/endometrial)

The following questions ask about some demographic information.

What race/ethnicity do you consider yourself?

O Asian
O African American/Black
O Caucasian/White
O Native American
O Hispanic
O Other _____

Please check the religion/ancestry from which you and your parents were born (check all that apply).

O Buddhist
O Catholic
O Eastern Orthodox
O Hindu
O Muslim
O Protestant
O LDS of Mormon
O Jewish- Ashkenazi (Eastern European)
O Jewish- Sephardic
O Other_____

If a physician asked you to fill out this form, please indicate which one:

O Antman
O Ditkoff
O Estabrook
O Garrett
O Geller
O Hesdorffer
O Kinne
O Krementz
O Mears
O Oster
O Moore
O Savage
O Schnabel
O Tiersten
O Vahdat
O Other_____

Thank you for your participation.