Children's Hospital
London Health Sciences Centre

Cancer Genetics Clinic, London Health Sciences Centre
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# PERSONAL HISTORY QUESTIONNAIRE

All answers provided are strictly confidential and will become part of your medical record.

## Personal Details

| | | | |
|---|---|---|---|
| Today's date: (DD/MM/YYYY) | | CG#: | |
| Full Name: | | | |
| Date of birth: (DD/MM/YYYY) | | | |
| Family physician(s): | | | |
| Current gender identity: | ☐Female ☐Male ☐Gender Queer/Non-Binary ☐Other: | | |
| Sex assigned at birth: | ☐Female ☐Male ☐Other: | | |
| Height: | _____ ft. _____ in. *OR* _____ cm. | Weight: | _____ lbs. *OR* _____ kg. |

## Gynecological Health (if applicable)

| | | | |
|---|---|---|---|
| How old were you when your menstrual cycles began? | | | |
| Have your periods stopped completely due to menopause? | ☐No ☐Yes → | How old were you? | |
| Have you ever taken the oral contraceptive pill? | ☐No ☐Yes → | How many years in total? | |
| | | Have you taken it in the last **2** years? | ☐No ☐Yes |
| Have you ever used hormone replacement therapy? | ☐No ☐Yes → | How many years in total? | |
| | | Have you used it in the last **5** years? | ☐No ☐Yes |
| Have you ever been pregnant? | ☐No ☐Yes → | How many children have you had? | |
| | | In what year was your first child born? | |
| Have you ever been diagnosed with endometriosis? | | | ☐No ☐Yes |

## Genetic Counselling/Testing History

| | | | |
|---|---|---|---|
| Have you ever had genetic counselling and/or genetic testing for cancer? | ☐Unsure ☐No ☐Yes<br>If "yes" please complete the section to the right → | Date: | |
| | | Genetics Centre: | |
| Have any family members ever had genetic counselling and/or genetic testing for cancer? | ☐Unsure ☐No ☐Yes<br>If "yes" please complete the section to the right → | Name of relative: | |
| | | Relationship to you: | |
| | | Genetics Centre: | |

## Cancer Screening

| Have you ever had any of the following cancer screening? | | | Most recent date | Findings (i.e. cysts, polyps, abnormal cells) |
|---|---|---|---|---|
| Breast | Mammogram | ☐No ☐Yes → | | |
| | Breast MRI | ☐No ☐Yes → | | |
| | Breast ultrasound | ☐No ☐Yes → | | |
| | Breast biopsy | ☐No ☐Yes → | | |
| Colorectal | FIT (stool sample) test | ☐No ☐Yes → | | |
| | Colonoscopy | ☐No ☐Yes → | | |
| Prostate | PSA blood test | ☐No ☐Yes → | | |
| | Digital rectal exam | ☐No ☐Yes → | | |
| Other (please specify): | | | | |

## Cancer History (if applicable)

| Type of cancer | Age at diagnosis | Treatment (i.e. radiation, chemotherapy, medications) (*for surgeries, please see below*) |
|---|---|---|
| | | |
| | | |
| | | |

## Surgical History

| Please check all surgeries/procedures which you have had in the past: | | | Year(s) |
|---|---|---|---|
| Breast | Lumpectomy | ☐Left only ☐Right only ☐Both | |
| | Mastectomy | ☐Left only ☐Right only ☐Both | |
| | Augmentation/implants | ☐Left only ☐Right only ☐Both | |
| | Other (please specify): | | |
| Gynecological | Oophorectomy (ovaries removed) | ☐Left only ☐Right only ☐Both | |
| | Salpingectomy (tubes removed) | ☐Left only ☐Right only ☐Both | |
| | Hysterectomy (uterus removed) | ☐Yes | |
| | Tubal ligation (tubes tied) | ☐Yes | |
| | Other (please specify): | | |
| Colon | Colectomy (colon removed) | ☐Partial ☐Full | |
| | Other (please specify): | | |
| Prostate | Colectomy (colon removed) | ☐Yes | |
| | Other (please specify): | | |
| Other (please specify): | | | |