Salem Health®
Hospitals & Clinics

Genetic Counseling Questionnaire

Please complete and return prior to your office visit with Nancy Ledbetter, RN, CNS.

Name _____ **DOB**_____ **MRN**_____

What is your main concern related to your upcoming genetic counseling visit? _____

_____

Your history:

1. Do you have now, or have you ever had a diagnosis of cancer? Yes / No
   If yes, what type of cancer have you had? _____

   How old were you at the time of your cancer diagnosis? _____

   Have you had cancer more than once? Yes / No

   Have you ever had genetic testing related to cancer? Yes / No

   If yes, please provide a copy of your genetic test result.
2. Have you ever had polyps in your colon, rectum or other gastrointestinal organs (e.g., stomach, small bowel)? Yes / No
   If yes, where were the polyps (e.g., colon, stomach)? _____

   How many polyps did you have? Please give the total number from all procedures as best as you know _____
3. Have you ever had thyroid growths, such as goiter or polyp? Yes / No
4. Have you ever been diagnosed with a sebaceous adenoma? Yes / No
5. Do you smoke or use tobacco? Yes / No
6. Have you ever smoked or used tobacco? Yes / No

   If yes, when did you quit? _____
7. How much alcohol do you drink per week? _____

Your family history:

1. Have any of your blood relatives had genetic testing related to cancer? Yes / No
   If yes, it is important that we have their test result for your evaluation.
   Do you have a copy of your relative's test result? Yes / No
2. What is your ethnicity/heritage on your mother's side? Circle all that apply.
   Asian, Black, Hispanic, Jewish, White, Other _____
3. What is your ethnicity/heritage on your father's side? Circle all that apply.
   Asian, Black, Hispanic, Jewish, White, Other _____
4. Do you have any blood relatives with breast cancer? Yes / No
   If yes, please circle relation: Mother, Father, Sister, Brother, Daughter, Grandmother—Maternal / Paternal, Aunt—Maternal / Paternal, Female Cousin—Maternal / Paternal, Other Male Relative, Other_____

   Were any relatives with breast cancer diagnosed prior to age 50? Yes / No
   If yes, which relatives? _____

5. Do you have any blood relatives with ovarian cancer? Yes / No
   If yes, please circle relation: Mother, Sister, Daughter, Grandmother—Maternal / Paternal,
   Aunt—Maternal / Paternal, Cousin—Maternal / Paternal, Other _____

6. Do you have relatives with colon or rectal cancer: Yes / No
   If yes, please circle relation: Mother, Father, Sister, Brother, Aunt, Uncle, Grandparent, Cousin,
   Other _____

   Were relatives with colon or rectal cancer diagnosed prior to age 50? Yes / No

7. Do you have any relatives with more than 10 colon polyps, and/or an inherited polyp problem? Yes / No

8. Do you have any blood relatives with uterine (endometrial) cancer? Yes / No
   If yes, please circle relation: Mother, Sister, Daughter, Grandmother—Maternal / Paternal,
   Aunt—Maternal / Paternal, Cousin—Maternal / Paternal, Other _____

   Were relatives with uterine cancer diagnosed prior to age 50? Yes / No

9. Do you have relatives with pancreatic cancer? Please list: _____
10. Do you have relatives with prostate cancer? Please list: _____
11. Do you have relatives with stomach cancer? Please list: _____
12. Do you have relatives with small bowel cancer? Please list: _____
13. Please list any other types of cancer in your family: _____

For women only:

1. How old were you when you had your first menstrual period? _____
2. If you have biological children, how old were you when your first child was born? _____
3. Have you ever had a breast biopsy? Yes / No
   If yes, how many breast biopsies have you had? _____

   If yes, did your breast biopsy show:
   - ☐ Atypical hyperplasia
   - ☐ Lobular intraepithelial neoplasia (LIN)
   - ☐ AKA Lobular carcinoma in situ (LCIS)
   - ☐ None of these

4. Have you had your tubes tied (tubal ligation)? Yes / No
5. Have you had surgery to remove your uterus (hysterectomy), fallopian tubes, or ovaries? Yes / No
   If yes, please choose type of surgery and indicate age:
   - ☐ Uterus only (hysterectomy) How old were you? _____
   - ☐ Fallopian tubes only (salpingectomy) How old were you? _____
   - ☐ Both ovaries (bilateral oophorectomy) How old were you? _____
   - ☐ One ovary (unilateral oophorectomy) How old were you? _____
   - ☐ One fallopian tube How old were you? _____
   - ☐ Uterus, both ovaries and both tubes removed How old were you? _____
   - ☐ Don't know surgery details How old were you? _____
6. Are you using, or have you ever used hormone replacement therapy? Yes / No

Please return your completed questionnaire prior to your appointment.

- Mail it in the postage-paid envelope if your appointment is more than one week away
- Fax it to 503-814-0457
- Scan and email to scigeneticsprogram@salemhealth.org *(Receives information only—there will be no reply)*