GENETIC SERVICES
OF WESTERN AUSTRALIA

Family History Questionnaire

Please return this paperwork by *even if it is not complete.*

Cancer is a common illness in our community, however only 5% of cancers are hereditary. The best way for us to accurately assess the risk of a gene fault running in your family is by collecting a detailed family history. These details will be treated in a confidential manner and we will not use it to contact other family members.

Should you have any questions or need assistance with this form, *please contact us – we are happy to help*.

Personal Details:

☐ Please confirm your details above are correct					
Email			Mobile		
What is your preferred method of contact?			(please circle one of each)		
Email	or	Post	SMS	or	Phone Call

Personal History:

Please provide details of any CANCERS or BOWEL POLYPS you have ever had.

Cancer or Polyp Type	Date of diagnosis	Treating doctor	Hospital

Please attach copies of relevant test reports, discharge summaries or specialist letters.

Your family history:

- Please include all your family members, even if they have not had cancer
- Try to collect as much information as possible, particularly from family members who have been diagnosed with cancer
- For twins, write identical or non-identical twin in the notes column
- If your family includes half siblings, write this in the notes column and indicate if they have the same mother or same father

Please sign below if you give consent for us to access your medical records confirming your medical history:

Signature: _____ Date: _____

Genetic Services of WA, 3rd Floor, Agnes Walsh House, 374 Bagot Road, Subiaco Western Australia 6008
Telephone (08) 6458 1603 Fax (08) 6458 1725 fcp@health.wa.gov.au
www.kemh.health.wa.gov.au/services/genetics

Your Immediate Family

	Full Name	Date of Birth	Type of Cancer (where it started)	Age or year of diagnosis	Doctor/Hospital	Deceased?	Notes
Example	*Mary Jones*	*1/1/64*	*Breast and ovarian*	*2013 and 2015*	*SCGH*	*N*	
Your Spouse							
Your Daughter/s							
Your Son/s							
Your Sister/s *include half sisters*							
Your Brother/s *include half brothers*							

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Your Maternal Family

	Full Name	Date of Birth	Type of Cancer (where it started)	Age or year of diagnosis	Doctor/Hospital	Deceased?	Notes
Your Mother							
Your Grandmother *mother's mother*							
Your Grandfather *mother's father*							
Your Aunt/s *mother's sisters*							
Your Uncle/s *mother's brothers*							
Other family members with cancer *E.g. nieces/nephews, cousins, great aunts/uncles*							

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Your Paternal Family

	Full Name	Date of Birth	Type of Cancer (where it started)	Age or year of diagnosis	Doctor/Hospital	Deceased?	Notes
Your Father							
Your Grandmother *father's mother*							
Your Grandfather *father's father*							
Your Aunt/s *father's sisters*							
Your Uncle/s *father's brothers*							
Other family members with cancer *E.g. nieces/nephews, cousins, great aunts/uncles*							

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Family Genetic Information

Has anyone in your family had genetic testing or attended a genetics clinic anywhere in the world?

YES / NO

If yes, please complete this table.

Full Name	Date of Birth	Relationship to you	Genetic Clinic Location

Your Ancestry:

Some conditions are more common in people with a shared background or in specific ancestries.

Is anyone in your family related by blood as well as by marriage? YES / NO
Details:

What is your ethnicity? _____

Are you of Aboriginal or Torres Strait Islander heritage? YES / NO

Do you have any Jewish ancestry? YES / NO
If so, is this on you mother's or father's side of the family, or both?

_____

What's Next?

Once you have completed this to the best of your ability, please return it, along with your Consent Forms, in the envelope provided.

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