

Return Completed Family History Form to:	
<input type="checkbox"/> Hereditary Cancer Program 32900 Marshall Road Abbotsford, V2S 0C2 Fax 604.851.4720 (T) 604.851.4710 ext 645174	<input type="checkbox"/> Hereditary Cancer Program 600 West 10 th Avenue Vancouver, V5Z 4E6 Fax: 604.707.5931 (T) 604.877.6000 ext 672198

Name: _____
BCC ID#: _____
DOB: _____

Family History

Please answer the following questions about your **blood** relatives (living and deceased) to help us give you the best care. Your best guesses about ages and other details are fine. This information will become part of your health record.

Are you adopted? No Yes **Were your parents adopted?** No Yes, mother Yes, father

Are your parents related to each other? (e.g. first cousins) No Yes – give relationship: _____

Your Children	How many daughters? _____ How many sons? _____	<input type="checkbox"/> I have no biological children
----------------------	--	--

Your Brothers and Sisters	How many sisters? _____ How many brothers? _____
<input type="checkbox"/> None	How many half-sisters? _____ How many half- brothers? _____ <input type="checkbox"/> Same mother <input type="checkbox"/> Same father

Your Mother's Side <input type="checkbox"/> No info	Is your mother alive? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is her current age or age at death? _____
	How many aunts do you have? _____	Are any of them your mother's half-sisters? <input type="checkbox"/> No <input type="checkbox"/> Yes
	How many uncles do you have? _____	Are any of them your mother's half-brothers? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Is your grandmother alive? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is her current age or age at death? _____
	Is your grandfather alive? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is his current age or age at death? _____

Your Father's Side <input type="checkbox"/> No info	Is your father alive? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is his current age or age at death? _____
	How many aunts do you have? _____	Are any of them your father's half-sisters? <input type="checkbox"/> No <input type="checkbox"/> Yes
	How many uncles do you have? _____	Are any of them your father's half-brothers? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Is your grandmother alive? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is her current age or age at death? _____
	Is your grandfather alive? <input type="checkbox"/> No <input type="checkbox"/> Yes	What is his current age or age at death? _____

Your Family's Ethnic/Ancestral Background: please check all that apply

	Africa/ Caribbean	Asia <input type="checkbox"/> East <input type="checkbox"/> South/Central	Europe/ UK	French Canadian	Indigenous (First Nations, Metis, Inuit)	Jewish <input type="checkbox"/> Ashkenazi <input type="checkbox"/> Sephardic	Middle East	South and Central America	Other: _____	Don't Know
Mother's mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father's father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Previous Cancer Genetics Appointment/Genetic Testing

Has anyone in your family had genetic counselling or genetic testing for the family history of cancer? No Yes

If yes, full name of relative(s): _____ Date of Birth or current age (if known): _____

Relationship to you: _____ Name and/or location of genetics clinic: _____

