A word Hereditary Cancer Risk Assessment Program

Feist-Weiller Cancer Center
LSU Health Sciences Center-Shreveport
1501 Kings Hwy
Shreveport, LA 71130

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Director, Breast Cancer Program

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Director, Molecular Pathology

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Mgr. Hereditary Cancer Risk Assessment Program
Cancer Genetics Educator
318-813-1226

Please print the forms and mail to Mary Gutowski-Futch RN, MSN
Feist-Weiller Cancer Center
LSUHSC-Shreveport
1501 Kings Hwy
Shreveport, LA. 71130

Thank you for your interest in the Hereditary Cancer Risk Assessment Program (HCRAP). If you would like to participate, complete the attached family history and risk factor questionnaire. Mail completed forms to: Mary Gutowski-Futch RN, MSN at above address.

Your first appointment will include a consultation with the Genetic Educator. The Genetic Educator will discuss the program, review your medical and family history and discuss significant risk factors. You will learn about genes, inheritance, genetic testing and monitoring options. The first appointment will take approximately 1 to 1 ½ hours.

Additional information may be obtained. This may include obtaining mammography reports, pathology reports, or confirming a history of cancer in the family by obtaining medical records. Assistance will be provided in obtaining all necessary information. Suitability for your participation in specialized early detection studies will be discussed.

Participant Information

Name: ____
(Last) (Maiden) (First) (Middle)

Address: ____
(Street)

____
(City) (ST) (Zip)

Phone No:
Home: ____________________________ Work: __________________________
(Area code) (Number) (Area code) (Number)

Email address:
____

Birth date: _____________ Social Security No: ___________________________

Spouse Name (optional) ____
(This is only for purpose of building family tree)

When is the best time to contact you? ___________________________________

Who referred you to the Hereditary Cancer Risk Assessment Program?

____

You, Your Parents & Your Grandparents

Name First, Last and (Maiden)	Date of Birth	Date of Death	Affected with Cancer? Yes or No	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of cancer Diagnosis
You						
Your Mother						
Your Father						
Your Mother's Mother						
Your Mother's Father						
Your Father's Mother						
Your Father's Father						

Your Brothers & Sisters

Name First, Last and (Maiden) M (male)or F (female)	Date of Birth	Date of Death	Affected with Cancer? Yes or No	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of Cancer Diagnosis
Sibling 1						
Sibling 2						
Sibling 3						
Sibling 4						
Sibling 5						

Your children (in order)

Name First, Last and (Maiden) M (male)or F (female)	Date of Birth	Date of Death	Affected with Cancer? Yes or No	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of Cancer Diagnosis
Child 1						
Child 2						
Child 3						
Child 4						
Child 5						
Child 6						

Your Aunts and Uncles *(Mother's Side)* (in order)

Name First, Last and (Maiden) M (male)or F (female)	Date of Birth	Date of Death	Affected with Cancer? Yes or No	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of Cancer Diagnosis
#1						
#2						
#3						
#4						
#5						
#6						

You're Aunts & Uncles *(Father's Side)* (in order)

Name First, Last and (Maiden) M (male)or F (female)	Date of Birth	Date of Death	Affected with Cancer? Yes or No	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of Cancer Diagnosis
#1						
#2						
#3						
#4						
#5						
#6						

Nieces & Nephews *(Children of Your Brothers & Sisters)*

Name First, Last and (Maiden) (and name of Parent)	Date of Birth	Date of Death	Affected with Cancer? Yes or No	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of Cancer Diagnosis
Niece 1 Parent:						
Niece 2 Parent:						
Niece 3 Parent:						
Nephew 1 Parent:						
Nephew 2 Parent:						
Nephew 3 Parent:						

Other Relatives with Cancer

Name if known and How related (Example: Mother's Father's Father's sister or Jane Doe's Mother's mother's brother) this helps in building family tree. First, Last name if known M (male)or F (female)	Date of Birth	Date of Death	Location of cancer (ex: breast, lung, etc)	Indicate if bilateral (both breasts for breast ca)	Age of Cancer Diagnosis
#1					
#2					
#3					
#4					
#5					
#6					
#7					
#8					
#9					
#10					

Personal Risk Assessment

Your background	
What is your race or ethnic background? (can indicate certain risks) If you are multi-racial, check all that apply	☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Middle Eastern ☐ Other:______________________ ☐ Ashkenazi Jewish ☐ European or other country descent : What country? _________________ What generation? _________________ (parents, grandparents, great grandparents)
What is the highest level of education you completed?	☐ Elementary School ☐ Middle School ☐ High School ☐ Some College ☐ College Degree ☐ Graduate Degree ☐ Professional School
What is your profession?	
Your Reproductive History	
How old were you when your menstrual periods began? How old were you when your menstrual periods became regular?	____ Years old ____ Years old
Are you experiencing any symptoms such as hot flashes? Have you gone through menopause?	☐ Yes ☐ No Natural _____ at what age___ Surgical _____ at what age___
Have you ever taken estrogen or hormone replacement pills?	☐ Yes ☐ No • If yes, for how long? _______years • name of Estrogen or Hormone:
Have you had your uterus removed?	☐ Yes ☐ No
Were your ovaries surgically removed? (oophorectomy)	☐ Yes ☐ No • if yes, check one: ☐ one ☐ both
How old were you when you had your first pregnancy?	__________ years old
How old were you when you had your first live-born child?	__________ years old
How many pregnancies have you had?	#
How many miscarriages have you had?	#
Have you ever used Birth Control Pills?	☐ Yes ☐ No • If yes, how many years? ________years
	☐ Yes ☐ No

Have you ever used medication to help you get pregnant? (ex: Clomid, Perganol)	if yes, indicate what medication you used:
Your Lifestyle History	
Have you ever smoked cigarettes?	☐ Yes ☐ No • *If yes*, what age did you start? ___ How many years have you smoked? ___ How many packs per day? ____ • *Do you still smoke? ___ how many packs per day?* ___
Do you ever drink alcoholic beverages?	☐ Yes ☐ No • *if yes*, how many drinks per week do you consume? #_____
Your Health History	
Do you have a history of breast problems?	☐ Yes ☐ No • If yes, what kind of breast problems have you had?
Have you ever had a breast biopsy?	☐ Yes ☐ No • If yes, how many have you had? #_______ • indicate what hospital(s) you went to for the biopsy(s) • what was the result(s) of the biopsy?
If you have had breast or other cancer, please indicate date and age of diagnosis. Date:_____________ Age: _____________	☐ Lumpectomy- Left Right ☐ Mastectomy- Left Right ☐ Other surgery: ___________________________ ☐ Chemotherapy- type:________________________ ☐ Radiation therapy ☐ Other __________________________________
When was your last gynecological exam?	__________Month ________Year
When was your last Mammogram?	__________Month ________Year

Do you ever do breast self-exam?	☐ Yes ☐ No If yes, how often? ___________________________
Do you feel confident about performing breast self-exam?	☐ Yes ☐ No
Do you have any ongoing health problems, such as heart disease, multiple sclerosis, osteoporosis, or any other conditions?	☐ Yes ☐ No Briefly describe any health problems here:
Do you take medications regularly?	☐ Yes ☐ No
Please write names of medications you take	
What concerns would you like to address during your visit to the Hereditary Cancer Risk Program?	