Patient Name:

DOB:

MR #:

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UW Health
(University of Wisconsin Hospitals and Clinics Authority)

HEMATOLOGY/ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE

Date: _____ Pronouns: _____

Please fill in the blanks below to the best of your ability.

Please list any cancer diagnosis and/or tumors you have had:

_____

_____

_____

Have you ever had genetic testing before: ☐ Yes ☐ No

What was the result?

_____

Have any of your family members had genetic testing before? ☐ Yes ☐ No

What was the result?

_____

If you or any of your biological family members have had genetic testing it is VERY IMPORTANT to bring a copy of the test results (from the lab that did the testing) to your appointment- even if everything was normal.

FAMILY HISTORY

Please fill in the blanks below. **Include all relatives** (those with cancer and those without). Please include deceased relatives. If additional space is needed, please attach a separate sheet of paper.

Please list your ancestry/background (i.e. German, Asian, African American, Jewish): _____

_____

Do you have **biological children?** ☐ Yes ☐ No Total number of children: _____

First name	Sex assigned at birth	Status	Age/Age at death	Cancer type?	Age at diagnosis
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			

Do you have **biological siblings?** ☐ Yes ☐ No Total number of siblings: _____

First name	Sex assigned at birth	Status	Age/Age at death	Cancer type?	Age at diagnosis
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			

Biological Maternal History

Is your **biological mother** still living? ☐ Yes ☐ No Age/Age at death: _____

History of cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

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UW Health
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HEMATOLOGY/ONCOLOGY GENETICS NEW PATIENT QUESTIONNAIRE

Does your **biological mother** have siblings? ☐ Yes ☐ No Total number of siblings: _____

First name	Sex assigned at birth	Status	Age/Age at death	Cancer type?	Age at diagnosis
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			

Is your biological mother's mother (**your grandma**) still living ☐ Yes ☐ No Age/Age at death: _____

History of cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

Is your biological mother's father (**your grandpa**) still living? ☐ Yes ☐ No Age/Age at death: _____

History of cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

Biological Paternal History

Is your **biological father** still living? ☐ Yes ☐ No Age/Age at death: _____

History of cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

Does your **biological father** have siblings? ☐ Yes ☐ No Total number of siblings: _____

First name	Sex assigned at birth	Status	Age/Age at death	Cancer type?	Age at diagnosis
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			
	☐ Male ☐ Female	☐ Living ☐ Deceased			

Is your biological father's mother (**your grandma**) still living? ☐ Yes ☐ No Age/Age at death: _____

History of cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

Is your biological father's father (**your grandpa**) still living? ☐ Yes ☐ No Age/Age at death: _____

History of cancer? ☐ Yes ☐ No Cancer type: _____ Age at diagnosis: _____

Signature of Patient/Representative: _____ Date: _____/_____/_____Time: _____

If signed by person other than the patient, print name and state relationship and authority to do so.

Print Name: _____ Relationship: _____

Patient is: ☐ Minor ☐ Incompetent/Incapacitated
☐ Legal Guardian ☐ Parent of Minor
☐ Health Care Agent ☐ Other

Reviewed by: _____ Date: _____/_____/_____Time: _____