Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston
Hôpital Hotel Dieu Hospital | KGH Hôpital Général de Kingston General Hospital

Queen's University

DIVISION OF MEDICAL GENETICS
Familial Oncology Program
Kingston Health Sciences Centre
Armstrong 4, 76 Stuart St,
Kingston, ON K7L 2V7
Tel: (613) 544-2631 ext. 2800
Fax: 613-545-5722

Medical and Family History Questionnaire

IMPORTANT: If your relative was seen for genetic counselling at our clinic or another genetic clinic, you may not need to complete this form. Please call our office prior to filling out this form for additional directions if this applies to you.

Please return your form as soon as possible. Options for returning your form:

1. Email to fop.genetics@kingstonhsc.ca
2. Fax to 613-545-5722
3. Mail to the Familial Oncology Program (address above)

Name of Patient: _____

Sex Assigned at Birth (IE: Male/Female/Other): _____

Gender Identity (IE: Male/Female/Non-Binary/Other): _____

Preferred Pronouns (IE: He/She/They/Other): _____

Patient's Date of Birth: _____/_____/_____(dd/mm/yyyy)

Person completing form: □ Patient □ Parent □ Other (specify relationship) _____

Tips for Completion:

1. Please reach out to your relatives for details. If you don't have specifics, please fill out as much as you can.
2. Include all biologically related family members, including those that are healthy. It is important for us to know the size of your family as part of the assessment.
3. If you have half-siblings, please note the parent that is shared with you/the patient.
4. For our purposes, the terms "Mother/Maternal" and "Father/Paternal" refers to the persons who contributed the egg and sperm to the pregnancy of the patient. We recognize that those individuals may not in fact be the "Mother" and "Father" of the patient as they define their parents. If you do not know this information, that is fine, please indicate that on this form.
5. If you don't know exact ages, please estimate (IE:. diagnosed in their 50s).
6. If you have too many relatives to fit in the space provided, please write any additional family history on a blank sheet of paper and include it when you return this form.
7. Any information shared with us is covered under the Personal Health Information Privacy Act (PHIPA) and will remain confidential, unless mandated otherwise by the Act or other Acts.

Breast Cancer Risk Assessment Form

(Please complete only if sex assigned at birth is female)

1. How tall are you? _____ feet _____ inches or _____ cm
2. What is your current weight? _____ lb or _____kg
3. Do you drink alcohol?
   - ☐ No
   - ☐ Yes
     - Glass of Wine (175ml) → daily, weekly, monthly? Amount _____
     - Pint of Beer, Lager, Cider (568ml) → daily, weekly, monthly? Amount _____
     - Bottle of Beer (Standard 330 ml) → daily, weekly, monthly? Amount _____
     - Alcoholic Pop Drink (275 ml) → daily, weekly, monthly? Amount _____
     - Shot of Spirits (25 ml), includes gin, rum, vodka, whisky, tequila, Sambuca → daily, weekly, monthly? Amount _____
4. How old were you when you started your period? _____
5. Have your periods now stopped completely for more than 6 months?
   ☐ No ☐ Yes → At what age? _____ ☐ Unknown
6. Have you ever taken the oral contraceptive pill?
   - ☐ No
   - ☐ Yes
     - For how many years in total? _____
     - Have you taken the pill in the last two years? _____
7. Have you ever used hormone replacement therapy (HRT) for menopause?
   - ☐ No
   - ☐ Yes
     - How many years in total have you used HRT? _____
     - Have you used HRT in the last five years? _____
     - What is the name of the HRT you have used (circle one)?
       - Known oestrogen monotherapy HRT
       - Known combined HRT
       - Other type of HRT
       - Unknown type of HRT
8. Have you ever had any children?
   - ☐ No
   - ☐ Yes
     - At what age did you have your first child? _____
9. Have you ever had a mammogram?
   - ☐ No
   - ☐ Yes
     - Breast density in BIRADS? _____
10. Have you ever been diagnosed with endometriosis?
    ☐ No ☐ Yes ☐ Unknown
11. Have you ever had your tubes tide (tubal ligation)?
    ☐ No ☐ Yes ☐ Unknown
12. Have you ever had both ovaries removed (oophorectomy)?
    ☐ No ☐ Yes ☐ Unknown
13. Have you ever had both breasts removed (mastectomy)?
    ☐ No ☐ Yes ☐ Unknown

Are your parents related by blood (IE: cousins or second cousins)? □ Yes □ No	
Maternal ancestry* ? □ Unknown	**Paternal ancestry*? □ Unknown**
Do you have any Ashkenazi Jewish ancestry? □ No □ Yes , mother/egg donor side □ Yes , father/sperm donor side	
*Ancestry in this context refers to either the group or groups that you identify as based on you/your family's origin or background. This can sometimes be captured in a distinct cultural group or may represent the country or countries from which you/your ancestors originated (IE: French Canadian / Indigenous / Ashkenazi Jewish or English / Chinese). Please list as many of these groups that apply to your family. Please note, we are looking for an ancestry other than "Canadian", so if you are unsure, please check the box.	

Relative	Name	Sex at Birth	Gender Identity (if different than sex at birth)	Living? Y/N	Age Now or Age at Death (estimate if unsure)	Cancer type and age at diagnosis
Example	*Robin Lee*	*F*		*N*	*65y*	*Breast Cancer dx at 64*
Your Biological Children □ None						
Full Siblings (brothers and sisters with the same mom & dad as you) □ None						
Maternal Half siblings (same mother/egg donor) □ None						
Paternal Half siblings (same father/sperm donor) □ None						

Maternal Side						
Relative	**Name**	**Sex at Birth**	**Gender Identity (If different than sex at birth)**	**Living? Y/N**	**Age Now or Age at Death (estimate if unsure)**	**Cancer type and age at diagnosis**
Mother/egg donor						
Grandmother						
Grandfather						
Aunts and Uncles (If half siblings to parents, please list M=mat, P=pat) □ None						

Paternal Side						
Relative	**Name**	**Sex at Birth**	**Gender Identity (If different than sex at birth)**	**Living? Y/N**	**Age Now or Age at Death (estimate if unsure)**	**Cancer type and age at diagnosis**
Father/sperm donor						
Grandmother						
Grandfather						
Aunts and Uncles (If half siblings to parents, please list M=mat, P=pat) □ None						

Extended Family Members with Related Health and/or Developmental Concerns							
Relative		**Relationship Notes**	**Side of Family (mat / pat)**	**Sex at Birth**	**Gender Identity**	**Living? (Y/N)**	**Cancer type and age at diagnosis**
Examples	*Cousin*	*Child of Mary Smith*	*Mat*	*F*	*F*	*Y*	
	Great-grandma	*Maternal grandma's mother*	*Mat*	*F*	*F*	*N*	

What are some of the concerns/questions you would like addressed/answered at your visit to the Genetics clinic?	
Has anyone in your family ever had genetic testing? If so, please provide a copy of the report or anything available to you (such as where testing was completed).	
If there is any other relevant information you think we should know, please tell us here.	

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PATIENT CONSENT FOR EMAIL CONTACT

I, _____ (please print Name of Patient/Substitute Decision Maker (SDM)), consent to making contact with authorized employees or *agents of the hospital for the purposes of communicating personal health information (PHI) via email. I understand that email communications will become the property of the hospital or its authorized agents and may be accessed for operational reasons of the hospital. I accept that the hospital cannot guarantee the security of email transmissions outside of the hospital protected network. I will notify my health care professional of any changes to my email address.

I have read the "Patient Consent for Email Contact" and understand and agree with the limitations and conditions in using email for communications.

*A person who performs work on behalf of the hospital and who receives appropriate training and access to hospital policies.

Email address: _____ As provided by: ☐ Telephone (staff validation)

(Please print clearly) ☐ In-person

Communication is authorized between: (Please check appropriate box)

☐ Patient

☐ Substitute Decision Maker (SDM)

☐ Family Member/Alternate: _____

Printed Name of Individual

Email may be used for:

- Conveying routine test results
- Scheduling appointments
- Certain counseling (e.g. nutrition)
- Other reasons as agreed upon by myself and my health care provider: _____

Email messages must have a concise subject line, relate to one subject and each message has to be separate. **(No email strings)**

Signature of Patient: _____ Date: _____
yyyy/mm/dd

Signature of Substitute Decision Maker (SDM): _____ Date: _____
(if applicable) yyyy/mm/dd

Witness: _____ _____ Date: _____
Printed Name Signature of Witness yyyy/mm/dd

For Institution Use Only

☐ **Email address entered into Patient Care System (PCS)**

Staff Signature:_____ **Printed Name:**_____ **Designation:**_____ **Date:**_____ **Time:**_____
yyyy/mm/dd hhmm

Patient Consent for Email Contact

- All agents of the hospital may use the patient's consent for email as outlined in the consent form unless the patient requests specific restrictions on such use.

- Email messages (email) are not encrypted on the hospital email system, and security and privacy can never be completely guaranteed.

- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the health care provider or patient. Email senders can easily misdirect an email, resulting in it being sent to many unintended or unknown recipients. Even when email messages are deleted, back-up copies may exist indefinitely. Email is a more permanent form of communication.

- Email is easier to falsify than handwritten or signed hardcopies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.

- Email can be delayed for technical reasons beyond the control of your care provider**. Do not use email to communicate emergency or urgent health matters**. Always consider the sensitivity of the email content and inherent risks before sending. Please tell your care provider if there are certain types of information you do not wish to discuss by email.

- You understand that the employer (KHSC) and on-line services have a legal right to inspect and keep email that pass through their system.

- You understand that it is impossible to verify the true identity of the sender. Be aware that email can introduce viruses into a computer system. Your care provider may choose not to open an email if the email address is not recognized or may choose not to receive an email if it looks like it may have a virus attached to it.

- Your care provider may make decisions about your treatment based on information you provide by email. Your email will become part of your patient record and as such may be used as evidence in court.

- At any time, you or your care provider can decide that you no longer wish to communicate by email. If you decide to stop communicating by email, you must inform your care provider in writing or at your next appointment. You will be asked to sign a "Revoking Consent for Email Contact" form which will cancel your consent to use email for communicating with your care provider.

- If your care provider cannot continue to communicate by email with you, he or she will inform you in writing and/or notify you about this at the time of your next appointment.

- It is the patient's responsibility to follow-up to determine whether the intended recipient received the email and that the recipient has responded.

- It is the patient's responsibility to ensure the hospital retains the correct email address.

- Email communications must not be used as a substitute for regular clinical examination.

- For questions about email communications, please speak to your care provider.