Patient Name: ________________________________ **Personal History Form- Male**

Appointment Date: ______________ Location: _____________________________

Directions: Please answer the following questions to the best of your knowledge. Please feel free to call us if you have any questions at 603-653-3541. Please complete and mail back to us in the envelope provided with our mailing address (DH-NCCC Familial Cancer Program One Medical Center Drive Lebanon, NH 03756 If you plan to mail your form, please mail it at least 2 weeks prior to your appointment.

Background Information:

1. Name:

2. DOB:

3. Have you ever had genetic testing for cancer in the past? Yes No

   If yes, please explain: ____

   Results: ___________________________________

4. Has anyone in your family had cancer genetic testing? Yes No

   If yes, how is this person related to you: __________________________

   Results: ___________________________________

PLEASE OBTAIN A COPY OF YOUR FAMILY MEMBER'S GENETIC TESTING RESULT. THIS RESULT IS REQUIRED FOR YOUR APPOINTMENT

5. Have you or a family member ever been diagnosed with a genetic condition? Yes No

   If yes, please explain: ____

6. What is your ancestry or ethnic background (what country/countries do your ancestors come from)?

Mother's mother's family: ____

Mother's father's family: ____

Father's mother's family: ____

Father's father's family: ____

7. Are any of your relatives of Ashkenazi Jewish Ancestry? Yes No Unsure

Personal Cancer History:

8. Have you ever had cancer? Yes No

   If yes, please list the type of cancer, age of diagnosis and treatment in the table below:

Type of cancer (specific name if known)	Age at diagnosis	Treatment

Personal Medical History:

9. Please fill out table with current or past cancer screening you have had

Type of screening	Yes or No	How often	Any unusual findings
Prostate Cancer Screening (PSA)			
Colonoscopy			
Other:			

10. Have you ever had colon polyps? Yes No

    If yes, how many? ____________________