

Personal details

Surname: _____

Forenames: _____

Date of birth: _____

Place of birth: _____

Gender: _____

Address: _____

Telephone: _____

E-Mail: _____

Referring Physician / Oncologist

Surname: _____

Forenames: _____

Hospital: _____

Address: _____

Telephone: _____

E-Mail: _____

Do you have children? Yes
 No

If YES:

Surname: _____	Surname: _____
Forenames: _____	Forenames: _____
Date of birth: _____	Date of birth: _____
Gender: _____	Gender: _____

Please provide details on further children on a separate sheet if necessary

Did you or your partner have miscarriages or abortions? Ja
 Nein

If YES, please provide further particulars hereto (e.g. how many miscarriages/ abortions, at which gestational week, reason for abortion [fetal malformation/ disorder?]):

Please provide details on further miscarriages/ abortions on a separate sheet if necessary
 Please provide medical reports/ documents etc., if applicable

QUESTIONNAIRE

Family History / Pedigree

The following question refers to your family over three generations. It comprises your own children – if applicable –, your own brothers and sisters and their children as well as your parents, your parents' siblings and their descendents. The question refers also to deceased relatives.

Are there any medical problems or health issues in your family?

(e.g. disabilities, malformations, epilepsy, mental health problems, cardiovascular disorders, diabetes, hearing or visual impairments)

Yes

No

If YES, please provide further particulars hereto (e.g. indicate the affected individual [exact relationship], and which medical problem/ issue occurred at what age; if deceased: at what age and cause of death):

Please provide details on further relatives on a separate sheet if necessary

Has a family member of yours been diagnosed with a tumour?

(e.g. breast cancer, ovarian cancer, colon cancer, pancreatic cancer, thyroid cancer, multiple endocrine neoplasia, multiple colon polyps)

Yes

No

If YES, please provide further particulars hereto (e.g. exact relationship to affected individual, and what kind of tumour was diagnosed at what age; if deceased: at what age and cause of death):

Please provide details on further relatives on a separate sheet if necessary

QUESTIONNAIRE

Medical History

What kind of tumour do you have?

(e.g. breast cancer, ovarian cancer, colon cancer, pancreatic cancer, thyroid cancer, multiple endocrine neoplasia, multiple colon polyps):

When was the tumour diagnosed?

Month: _____ Year: _____

What kind of treatments have been performed to date?

(e.g. surgery, radiotherapy, chemotherapy, antihormone therapy):

Please provide medical reports/ documents etc., if applicable

Did you have any other tumours in the past? Yes No

If YES, please provide further particulars hereto (e.g. what kind of tumour was diagnosed at what age, what kind of treatment was administered [e.g. surgery, radiotherapy, chemotherapy, other]):

Please provide medical reports/ documents etc., if applicable

Do you have any other health issues or pre-existing conditions? Yes No

If YES, please provide further particulars hereto (e.g. malformations, epilepsy, mental health issues, cardiovascular disorders, Liver/ kidney disorders, urogenital particularities, diabetes, thyroid problems, surgeries, clotting disorders, hearing or visual impairments) including treatments/ therapies/ medication/ in-patient stays, if applicable:

Please provide medical reports/ documents etc., if applicable

QUESTIONNAIRE

Medical History

Do you consume alcohol, illegal substances [drugs] or do you smoke? Yes
 No

If YES, please provide further particulars hereto (e.g. which substance, since when and how long for):

Please provide your most recent body measurements

Height: _____ Date measured: _____

Weight: _____ Date weighted: _____

Head circumference: _____ Date measured: _____

Comments

Is there anything else you would like to share, anything special or remarkable? Please tell us about it here:

Thank you for your time and patience.