UF Health
CANCER CENTER
ORLANDO HEALTH

1400 S. Orange Ave.
Orlando, FL 32806
407.648.3800

UFHealthCancerOrlando.com

You have been referred for genetic counseling by your doctor because of your personal or family history of cancer. Most cancer is not hereditary and if your doctor referred you for genetic counseling, it does not mean that your family has a hereditary form of cancer. Genetic counseling helps individuals assess whether their cancer or the cancer in their family is hereditary which can help them and their family members make important medical decisions.

Before our initial appointment, it is helpful to know more information about your medical history and your family history. By completing the enclosed genetic risk assessment questionnaire, it will let us know who in your family has a history of cancer and to learn some of your health concerns. It may also be helpful to obtain medical records from other family members.

- **Please complete the questionnaire. Make sure to list all of your relatives (with and without cancer). If you are uncertain about any information, please write in your best estimate.**
- **Keep a copy for yourself.**
- **Mail, email or fax a copy to our office.**
- **After we receive a copy of your questionnaire and it has been reviewed, we will contact you to schedule a genetic counseling appointment.**

Genetic counseling typically requires up to two visits. During your initial appointment, you will undergo a genetics focused physical exam with a nurse practitioner who will look for physical signs of a hereditary form of cancer. You will then meet with a genetic counselor who will review your history, explain hereditary forms of cancer, review the pros/cons of genetic testing and discuss management plans. If genetic testing is appropriate and desired, we can proceed with genetic testing and/or insurance pre-authorization. The second visit involves disclosure of the results and a discussion of your medical management.

Please be aware that the cost of genetic testing *is not included* with the consultation. During your initial appointment, the genetic counselor will help you in determining if the cost of genetic testing will be covered by your health insurance.

To return the questionnaire:
Fax: (321) 843-6025
Mail: Connie Edwards - Cancer Genetics, MP 710-11
UF Health Cancer Center – Orlando Health
1400 South Orange Ave, Orlando, FL 32806
Email: Cancer.Genetics@OrlandoHealth.com

Please feel free to call (321) 841-GENE if you have any questions about the process.

Sincerely,

Ryan Bisson, MS, CGC
Genetic Counselor
UF Health Cancer Center – Orlando Health

GENETIC RISK ASSESSMENT – Personal History

Put an X in the space next to the category that is most accurate or fill out as indicated.
Please circle Y (yes), N (no) or U (unknown).

BACKGROUND INFORMATION

What is your date of birth? ___/____/____ **What is your occupation** _____

Name _____(_____)_____ SS#:_____
First Name Maiden/Family Name Last Name

Address: _____ City: _____ State: ____ ZipCode: _____

Phone #(_____)_____ Best Daytime Phone # (_____)_____

What is the best time to contact you? _____

Referring physician: _____ Insurance Carrier:_____

What is the highest level of education you have completed?

❑ Elementary School ❑ Some High School ❑ High School ❑ Some College ❑ College Degree

Primary language: _____ If English is not your primary language, will you need a translator ❑ Yes ❑ No

Please choose which ethnic/racial background best describes you and your biological parents

(Check all that apply) ❑ White/Caucasian ❑ Black or African-American

❑ Spanish, Hispanic or Latino ❑ Asian ❑ Unknown ❑ Other _____

What regions did your ancestors come from? (example: England, Nigeria, Mexico, Taiwan)

Maternal Side: _____ Paternal Side: _____

Are either of your parents of Ashkenazi (Eastern/Central European) Jewish descent? ❑ Yes ❑ No

GENERAL MEDICAL HISTORY

How is your health in general? _____

Have you ever been diagnosed with any cancer? Y N U

If yes, what type(s) and at what age(s) were you diagnosed?

Age	Cancer Type	Treatment (Circle all that apply)
_____	_____	Surgery Chemotherapy Radiation Therapy
_____	_____	Surgery Chemotherapy Radiation Therapy
_____	_____	Surgery Chemotherapy Radiation Therapy

Notes _____

_____

_____

_____

GENETIC HEALTH REVIEW

Name: *Patient Label Here*

Date of Birth:

	Yes	No	Staff Comments
Constitutional/Nutrition			
Lack of appetite			
Weight Loss/Weight Gain			
Fevers			
Chills			
Eyes			
Blurred vision			
Eye pain			
Loss of vision			
Ear/Nose/Mouth/Throat			
Extra teeth (besides wisdom teeth)			
Gum lesions			
Tongue lesions			
Heart/Cardiovascular			
Chest pain			
Irregular heart beat			
Heart disease			
Respiratory			
Cough			
Shortness of breath			
Wheezing			
Gastrointestinal			
Constipation			
Diarrhea			
Blood in stool			
Jaundice or yellow skin/eyes			
Change in stool			
Abdominal pain			
Have you undergone a colonoscopy			
Date of last colonoscopy			
How often do you undergo colonoscopies			
Colon polyps			
If so, at what age			
If so, how many polyps			
Colectomy (removal of colon)			
If so, what was the reason?			
Genitourinary			
Pain with urination			
Blood in urine			

GENETIC HEALTH REVIEW

Name: *Patient Label Here*

Date of Birth:

	Yes	No	Staff Comments
Breast			
Pain (what side)?			
Lump (what side)?			
Dimpling of skin			
Nipple changes/discharge			
Skin changes			
Do you undergo regular mammograms			
How often			
Date of last mammogram			
Do you undergo breast MRI screening			
How often			
Mastectomy (removal of breast)			
If so, where both breasts removed			
Skin			
Freckles on lips/genitalia			
Rash			
Lesions removed from your hands, feet, face or mouth			
Musculoskeletal			
Joint pain			
Back pain			
Neurological			
Headaches			
Seizure			
Endocrine			
Thyroid abnormality			
Thyroid problems			
Thyroidectomy (removal of thyroid)			
Amenorrhea (lack of menses, not menopausal)			
High Calcium			
Skin/Hair dryness			
Insomnia			
Hematologic/Lymphatic			
Red or purple skin discolorations			
Enlarged Lymph nodes			
Anemia			
Bleeding/History of blood clot			

GENETIC HEALTH REVIEW

Name: *Patient Label Here*

Date of Birth:

	Yes	No	Staff Comments
Allergy/Immunology			
Medications			
Environmental/Seasonal			
Foods			
Psychiatric			
Depression			
Anxiety			
Male			
Date of last prostate exam			
Prostate Biopsies			
Female			
Age at first menses			
Age at first live birth			
Number of pregnancies			
Number of live births			
Date of last pelvic exam			
Hot flashes			
Pelvic pain			
Vaginal bleeding/discharge			
Vaginal dryness			
Menopause			
If so, at what age			
Use oral contraceptives			
Use hormonal replacement therapy			
Regular gynecologic cancer screening			
Hysterectomy (removal of uterus)			
If so, at what age			
Oophorectomy (removal of ovaries)			
If so, at what age			
If so, where both ovaries removed			
Past Medical History			
Osteoporosis/osteopenia			
Scleroderma			
Lupus			
Dermatomyositis			
Diabetes			
High cholesterol			
High blood pressure			
List any surgeries (please state year)			

GENETIC HEALTH REVIEW

Name: *Patient Label Here*

Date of Birth:

		Staff Comments
Referring Physician	**Address/Phone**	
Primary Care Physician		
OB/GYN		
List All Other Physicians		
Martial Status	Please check one	
Married		
Divorced		
Widowed		
Single		
Significant other		
Separated		
Employment Status		
Employed occupation/job description		
Umemployed		
Retired		
Homemaker		
Student		
Exposures		
Chemical		
Radiation		
Other:		
What concerns would you like addressed during your genetic counseling appointment?		

GENETIC RISK ASSESSMENT – FAMILY HISTORY

YOUR BIOLOGICAL PARENTS

Name	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or General health
Example: Joe	(A) / D	68	(Y) / N	55	Prostate Cancer
Mother:	A / D		Y / N		
Father:	A / D		Y / N		

YOUR BIOLOGICAL GRANDPARENTS

Name	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or General health
Your Mother's Mother	A / D		Y / N		
Your Mother's Father	A / D		Y / N		
Your Father's Mother	A / D		Y / N		
Your Father's Father	A / D		Y / N		

YOUR BIOLOGICAL CHILDREN

Name	Sex	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or General health
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		

Have any of your family members undergone genetic testing: Y N U

If yes, who had testing and what were the results?

_____

_____

Notes/Additional Information:

_____

_____

YOUR BIOLOGICAL BROTHERS AND SISTERS (include full and half siblings)

Name	Sex	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or General health
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		

Do you and all of your siblings have the same mother and father? Yes No
If not, please indicate which siblings have the same parents: _____

_____

YOUR MATERNAL AUNTS & UNCLES (your mother's brothers and sisters)

Name	Sex	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or General health
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		

YOUR PATERNAL AUNTS & UNCLES (your father's brothers and sisters)

Name	Sex	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or General health
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		
	M / F	A / D		Y / N		

Notes/Additional Information:_____

_____

YOUR MATERNAL COUSINS (Children of your maternal aunts/uncles)

Name	Sex	Child of who?	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or general health
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		

YOUR PATERNAL COUSINS (Children of your paternal aunts/uncles)

Name	Sex	Child of who?	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or general health
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		

YOUR NIECES & NEPHEWS (Children of your brothers & sisters)

Name	Sex	Child of which sibling?	Alive or deceased?	Current age or age at death	Affected with cancer?	Age at cancer diagnosis	Cancer type or general health
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		
	M / F		A / D		Y / N		

Notes/Additional Information:_____

_____

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ORLANDO HEALTH®
1414 Kuhl Ave. • Orlando, FL 32806

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

LINE UP PATIENT I.D. LABEL HERE

UNIVERSAL PATIENT AUTHORIZATION FORM FOR FULL DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT & QUALITY OF CARE

PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____

Social Security Number (optional):_____Date of Birth (mm/dd/yyyy):_____

Address:_____City:_____State:_____Zip:_____

You may use this form to allow your healthcare provider to see and obtain access to your health information. Your choice on whether to sign this form will not affect your ability to get medical care or health insurance coverage and cannot be used as the basis for denial of health services.

By signing this form, I voluntarily authorize and give my permission and allow disclosure:

OF WHAT: ALL MY HEALTH INFORMATION including any information about sensitive conditions (if any) [See page 2 for details]

FROM WHOM: ALL information sources [See page 2 for details]

TO WHOM: Specific person(s) or organization(s) permitted to receive my information (must be a healthcare provider): Orlando Health, Inc. and all Orlando Health sites and locations including UF Health Cancer Center Orlando, South Lake Hospital, Orlando Health Central, Orlando Health Physician Group, and Physician Associates LLC.

PURPOSE: To provide me with medical treatment and related services, and to evaluate and improve patient safety and the quality of medical care provided to all patients.

EFFECTIVE PERIOD: This authorization/permission form will remain in effect until the day you withdraw your permission.

WITHDRAWING YOUR PERMISSION: You can withdraw your permission at any time by giving written notice to the person or organization named above in "To Whom."

In addition:

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons [See page 2 for details].
- **I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.**
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

X _____ _____

Signature of Patient or Patient's Legal Representative — Date Signed (mm/dd/yyyy)

Print Name of Legal Representative (if applicable)

_____

Check one to describe the relationship of Legal Representative to Patient (if applicable):

- ❑ Parent of minor
- ❑ Guardian
- ❑ Other personal representative (explain:_____)

NOTE: This form is invalid if modified. You are entitled to get a copy of this form after you sign it.