

BAYLOR/TEXAS MEDICAL CENTER, HOUSTON CHILDREN'S HOSPITAL, DENVER CHILDREN'S HOSPITAL OF COLUMBUS CHILDREN'S HOSPITAL OF LOS ANGELES CHILDREN'S HOSPITAL & MEDICAL CENTER, SEATTLE CHILDREN'S HOSPITAL OF PHILADELPHIA CHILDREN'S HOSPITAL OF PITTSBURGH CHILDREN'S MEDICAL CENTER, BOSTON CHILDREN'S HOSPITAL OF CHICAGO CHILDREN'S HOSPITAL OF CHICAGO MEDICAL CENTER, HOUSTON MEMORIAL SLOAN-KETTERING CANCER CENTER, NEW YORK MINNEAPOLIS CHILDREN'S MEDICAL CENTER MOTT CHILDREN'S HOSPITAL, ANN ARBOR RILEY CHILDREN'S HOSPITAL, INDIANAPOLIS ST. JUDE CHILDREN'S RESEARCH HOSPITAL, MEMPHIS STANFORD UNIV. SCHOOL OF MEDICINE, PALO ALTO UCLY MEDICAL CENTER, LOS ANGELES UCSF SCHOOL OF MEDICINE, SAN FRANCISCO UNIVERSITY OF ALABAMA, BIRMINGHAM UNIVERSITY OF MINNESOTA, MINNEAPOLIS UT-SOUTHWESTERN MEDICAL CENTER, DALLAS ROSWELL PARK, BUFFALO HOSPITAL FOR SICK CHILDREN, TORONTO

Long-Term Follow-Up Study

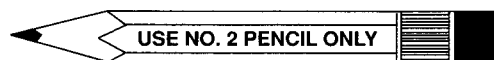
Family History Questionnaire

The questions in this booklet relate to

Today's date _____
 (month/day/year)

Please follow these few simple rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call **1-800-775-2167**.

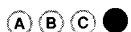
1. Use the **No. 2 pencil enclosed** (Please do *not* use pen).



2. Darken completely the circle of the answers.

Written responses must stay within the boxes provided.

CORRECT



INCORRECT



CORRECT



INCORRECT



3. Make no stray marks of any kind. Other than your responses, please keep the form as clean as possible. Erase cleanly any answer you wish to change. Do not use "white-out".

EXAMPLE OF FAMILY HISTORY

Full Name (First, Middle, Last)	Sex	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Birth Defect, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
John Paul Smith	<input checked="" type="radio"/> Male <input type="radio"/> Female	5/11/51	<input checked="" type="radio"/> Alive <input type="radio"/> Dead		None	
Sharon Marie Smith	<input type="radio"/> Male <input checked="" type="radio"/> Female	6/29/55	<input type="radio"/> Alive <input checked="" type="radio"/> Dead	11/5/90	Leukemia	29
Peter Quintin Smith	<input checked="" type="radio"/> Male <input type="radio"/> Female	2/15/62	<input checked="" type="radio"/> Alive <input type="radio"/> Dead		Aniridia Wilms Tumor	0 3
Unnamed (stillbirth)	<input type="radio"/> Male <input checked="" type="radio"/> Female	4/20/63	<input type="radio"/> Alive <input checked="" type="radio"/> Dead	4/20/63	None	

FAMILY HISTORY INFORMATION

Conditions or illnesses occurring in family members may be important clues in determining our genetic make-up. This section of the questionnaire deals with cancer, conditions present at birth, and hereditary conditions which may be present in you or in your family members. Please use the list below to complete the following section.

Cancer

Any diagnosis of cancer or malignant tumor, such as:

Leukemia	Wilms tumor
Retinoblastoma	Lymphoma
Brain tumor	Teratoma
Hodgkins disease	Seminoma
Sarcoma	Neuroblastoma
Germ cell tumor	Carcinoma
Cancer - Any other type, or location unknown	
Skin cancer - please note if melanoma or non-melanoma. (Non-melanoma, also called basal cell or squamous cell carcinoma of the skin, is usually removed in the doctors office, with no further treatment needed.)	

Conditions Present At Birth

Any abnormality present at birth, such as:

Blindness or difficulty seeing	Hole in the heart
Crossed eyes (Strabismus)	Other congenital heart defect
Eyes different colors	Mongolism (Down's syndrome, Trisomy 21)
Hare lip (Cleft lip)	Open spine (Spina bifida)
Hole in roof of mouth (Cleft palate)	Exposed brain (Anencephaly)
Absent, fused or extra fingers or toes	Large or multiple birth marks
Hip displacement	Water on the brain (Hydrocephalus)
Diverted urinary stream (Hypospadias)	Macrocephaly (Enlarged head)
Undescended testicle (Cryptorchism)	Microcephaly (Small head)
Deafness or impaired hearing	Hemihypertrophy (Enlargement of one arm or leg)
Shortened limbs	Deformed chest
Club foot	Other skeletal abnormality

Hereditary Conditions

Some of the more common conditions known to be hereditary:

Achondroplasia	Multiple polyposis
Acrocephalosyndactyly	Myotonic dystrophy
Aniridia	Neurofibromatosis (type 1)
Apert's syndrome	Nevoid basal cell carcinoma syndrome
Ataxia-telangiectasia	Osteogenesis imperfecta
Beckwith-Wiedemann syndrome	Polycystic disease of the kidney
Bilateral acoustic neurofibromatosis (type 2)	Polyposis coli (Gardner's syndrome)
Bloom's syndrome	Tuberous sclerosis
Congenital megacolon (Hirschsprung's disease)	Turner's syndrome
Cystic fibrosis	von Hippel-Lindau syndrome
Fanconi's anemia	von Recklinghausen's disease
Klinefelter's syndrome	Wiskott-Aldrich syndrome
Marfan's syndrome	Xeroderma pigmentosum
Multiple exostoses	

Your Mother's Family

- Please complete this section on all members of the mother's side of ♦ family. It is very important that you include everyone, even those family members who did not have conditions listed on the previous page.
- If a family member has had a history of cancer, a condition present at birth, and/or one of the hereditary conditions listed on the previous page, please write the type of cancer, birth defect, or hereditary condition into the spaces provided. Fill out this medical history section whether this person is alive or dead. If the person died of another cause (like an accident) and never had any of these illnesses, or if the person is still living and does not have any of these, write NONE in the medical history section.
- See family history example on the front cover.

1.a Parents of ♦ Mother:

This section concerns the natural parents of ♦ mother (♦ grandparents).

Full Name (First, Middle, Last)	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Condition Present at Birth, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
Mother		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
Father		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			

1.b Mother's Full Brothers and Sisters:

Please write in the names of all of ♦ mother's brothers (♦ uncles) and sisters (♦ aunts) in this section, whether they have had one of these conditions or not.

Full Name (First, Middle, Last)	Sex	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Condition Present at Birth, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			

(If you need more space, please use a separate sheet of paper, and attach to this page.)



Your Father's Family

- Please complete this section on all members of the father's side of ♦ family. It is very important that you include everyone, even those family members who did not have conditions listed on the previous page.
- If a family member has had a history of cancer, a condition present at birth, and/or one of the hereditary conditions listed on the previous page, please write the type of cancer, birth defect, or hereditary condition into the spaces provided. Fill out this medical history section whether this person is alive or dead. If the person died of another cause (like an accident) and never had any of these illnesses, or if the person is still living and does not have any of these, write NONE in the medical history section.
- See family history example on the front cover.

1.a Parents of ♦ Father:

This section concerns the natural parents of ♦ father (♦ grandparents).

Full Name (First, Middle, Last)	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Condition Present at Birth, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
Mother		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
Father		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			

1.b Father's Full Brothers and Sisters:

Please write in the names of all of ♦ father's brothers (♦ uncles) and sisters (♦ aunts) in this section, whether they have had one of these conditions or not.

Full Name (First, Middle, Last)	Sex	Date of Birth (Mo/Day/Yr)	Status	Date of Death (Mo/Day/Yr)	Medical History of Cancer, Condition Present at Birth, Hereditary Condition (provide specific type)	Age of Onset (yrs.)
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			
	<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Alive <input type="checkbox"/> Dead			

(If you need more space, please use a separate sheet of paper, and attach to this page.)

**After completing this questionnaire, please return by using
the enclosed envelope, and mail to:**

**Leslie L. Robison, Ph.D.
University of Minnesota
Suite 300
1300 S. Second St.
Minneapolis, MN 55454**

Again, thank you for your help and your participation in this study!