Hereditary Cancer Genetic Counseling Questionnaire



Patient Information

Last Name		First Name	First Name			
Date of Birth	Age	Occupation	Occupation			
Street Address						
City	State		Zip			
Phone Number		Email				
Sex at birth: Male	ex at birth: Male Female		Weight (pounds)			
Referring Healthcare	e Provider					
Healthcare Provider Name						
Clinic Name						
Street Address						
City	State		Phone			
Medical History						
	u ever had a diagnosis of cancer? w table with all primary cancer diag	Yes No	Unsure			
Cancer type	Cancer type Age at diagnosis		Additional information			
Have you ever had polyps?	Yes No	Unsure				
f yes, please complete the belo	w table with all types of polyps.					

Locations of polyps (e.g. colon, rectum, stomach, small bowel)	Polyp type	Number of polyps	Age at diagnosis

The following questions are for individuals that answered 'sex at birth: female'. If this is not applicable to you, please move on to the Cancer Screening section:

How old were you when you had your	first menstrual period?				
Have you given birth?	Yes No If yes, how old were you when your first child was born?				
Have you gone through menopause?	Yes No Perimenopausal Unsure If yes, at what age?				
Are you using or have you ever used t	he following?				
Birth control pills	Yes No Unsure If yes, for how long?				
Chemoprevention (e.g. Tamoxifen)	Yes No Unsure If yes, for how long?				
Have you ever used hormone replace	ment therapy (HRT) such as estrogen or progesterone?				
If yes, please answer the followi	ng questions:				
What type?	Estrogen only Estrogen & Progesterone (combined) Unknown				
Are you currently using HRT?	Yes No If no, how long ago did you stop?				
How many years have you been using / did you use HRT?					
If you have not had breast cancer, plea	ase complete the following questions:				
Have you ever had a breast biopsy?	Yes No Unsure If yes, how many? One Two or more				
Cancer Screening Histor	У				
Have you ever had a mammogram?	Yes No Unsure If yes, how often?				
Have you ever had a breast MRI?	Yes No Unsure If yes, how often?				
Have you ever had a colonoscopy?	Yes No Unsure If yes, how often?				
Any other cancer screenings and how	often?				
L					

Family Background

Are you adopted?	Yes	No	Unsure
Are you of Ashkenazi Jewish descent?	Yes	No	Unsure

Please list any biological family members with cancer below. Include parents, children, siblings, aunts, uncles, first cousins, nieces, nephews, and grandparents.

Relative	Maternal/Paternal side of family (if relevant)	Relative's first name	Cancer type(s)	Age(s) at Diagnosis

Previous Testing Information					
Have you or any relatives ever had genetic testing relation	ed to cancer?	Yes	No		Unsure
If yes, which relative? What w	vas the result?	Positive	Negative		Inconclusive
If positive, please specify the gene?					

*Please include the genetic test report documenting the results.

Patient Acknowledgement

I have read (or had someone read to me) the Genetic Counseling Patient Acknowledgement. The information provided in this form is correct and accurate to the best of my knowledge. Natera may use the information included herein to contact me for clinical follow-up, results, billing/collection matters and health-related products, services or studies.

Patient signature

Date

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The tests described have been developed and their performance characteristics determined by the CLIA-certified laboratory performing the test. The tests have not been cleared or approved by the US Food and Drug Administration (FDA). Although FDA is exercising enforcement discretion of premarket review and other regulations for laboratory-developed tests in the US, certification of the laboratory is required under CLIA to ensure the quality and validity of the tests. CAP accredited, ISO 13485 certified, and CLIA certified. © 2022 Natera, Inc. All Rights Reserved. NAT_GD_Hereditary Cancer Genetic Counseling Questionnaire_20220113_NAT-9000081 | MLB-10610 Rev. 03

