PRIOR TO VISIT, please complete and fax to 212-860-3316 or mail to:
Mount Sinai Medical Center
1 Gustave L. Levy Place
Box 1497
New York, NY 10029

Family History Information for Genetic Studies

Name: ______________________________

Date of Birth: ______________________________

Date of Appointment: ______________________

IMPORTANT: Please include ALL relatives, whether or not they have had cancer

Relationship	First Name	Did this person have cancer? ***If yes, list type of cancer & age at diagnosis***	Is this person living or deceased?	
			If living, list approximate age	If deceased, list cause of & age at death
Yourself				
Your spouse				
Your child: M / F				
Your child: M / F				
Your child: M / F				
Your Father				
Your Mother				
Your Sibling: M / F				
Your Sibling: M / F				
Your Sibling: M / F				
YOUR MOTHER'S RELATIVES:				
Her Father				
Her Mother				
Her Sibling: M / F				
Her Sibling: M / F				
Her Sibling: M / F				
YOUR FATHER'S RELATIVES:				
His Father				
His Mother				
His Sibling: M / F				
His Sibling: M / F				
His Sibling: M / F				

	Ethnic Origin (e.g. Italian, Irish, German)	Religion
Mother's father		
Mother's mother		
Father's father		
Father's mother		

If you or either of your parents has more siblings than are indicated on this form, please add them on the back of this page

If you have any other relatives with a history of cancer, please add them on the back of this page

Please list any additional relatives here:

Relationship How is this person related to you? (please also circle M = Maternal or P = Paternal)	**First Name**	**Did this person have cancer?** ***If yes, list type of cancer & age at diagnosis***	**Is this person living or deceased?**	
			If living, list approximate age	If deceased, list cause of & age at death
(M / P)				
(M / P)				
(M / P)				
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