

You have been referred to the Gastrointestinal Cancer Risk Evaluation Program (GI CREP) to evaluate your personal and family history for the presence of inherited increased risk for gastrointestinal cancers, as well as to discuss risk reduction options for you and your family members. Your participation in this program can also help you determine whether testing for the inherited forms of cancer may be right for you. During your visit you will be seen by a certified genetics counselor as well as a gastroenterologist.

Please complete the enclosed paperwork and return to Samantha at:

Division of Gastroenterology
415 Curie Blvd.
600 CRB
University of Pennsylvania
Philadelphia, PA 19104

Or:

Fax: 215-573-2024
scadieux@mail.med.upenn.edu

Please fill out the questionnaires to the best of your ability; if you do not know exact dates/ages, and estimate will be fine. After we have this information, we will assist you in obtaining any additional medical information if necessary for your evaluation.

After we receive your completed paperwork, we will call to schedule you for an appointment. Once you have an appointment, a packet will be mailed to you including a map and directions to the clinic.

Evaluations in the GI Cancer Risk Evaluation Program are a part of a clinical service, and will be billed for as an encounter with a medical team. HUP accepts most insurance plans. If your insurance requires a referral to be seen by a specialist, then a referral will be needed to ensure that you are not billed separately for this service. Your co-pay must be paid at the time of the visit. If we do not receive payment at the visit, there will be an additional charge of \$12.00 to cover cost of creating and sending an invoice to you. We are happy to assist you with any insurance or billing questions you may have prior to your appointment with us. Depending on your personal situation, you may also be offered participation in research studies. Whether or not you choose to participate in research will in no way influence the medical care you receive.

If you have any further questions, feel free to call me at 215-898-0154. We look forward to meeting you!

Sincerely,

Samantha Halter
GI Genetics Coordinator

*University of Pennsylvania Medical Center
GI Cancer Risk Evaluation Program
Divisions of Gastroenterology and Medical Genetics*

What is your primary reason for coming to the GI Cancer Risk Evaluation Program?

Are there specific concerns you would like addressed at your visit?

1.) Demographics

Name: _____ Date of Birth: _____

What is your level of education?

- | | |
|---|---|
| <input type="checkbox"/> Less than eight years | <input type="checkbox"/> Some college or technical school |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> Graduated from college |
| <input type="checkbox"/> Graduated from high school/GED | <input type="checkbox"/> Graduate school |

What is your current occupation? _____

Ethnic Background (Irish, French, German, etc.): Mother's side: _____

Father's side: _____

Religious Background (Catholic, Jewish, etc.): Mother's side: _____

Father's side: _____

2.) Personal Cancer History

A.) Have you ever had cancer? Yes No

If yes, what type (i.e. colon, pancreatic, skin, etc.)? _____

When were you diagnosed? _____

What type of surgery did you have? _____

Where was the surgery performed? _____

Hospital

State

Did you have chemotherapy? Yes No

If yes, where was the chemotherapy completed? _____

Hospital

State

Did you have radiation therapy? Yes No

If yes, where was the radiation therapy completed? _____

Hospital

State

B.) Have you had more than one cancer? Yes No
 If yes, what was the second type (i.e. colon, pancreatic, skin, etc.)? _____
 When were you diagnosed? _____
 What type of surgery did you have? _____
 Where was the surgery performed? _____
Hospital State
 Did you have chemotherapy? Yes No
 If yes, where was the chemotherapy completed? _____
Hospital State
 Did you have radiation therapy? Yes No
 If yes, where was the radiation therapy completed? _____
Hospital State

3.) *Genetic Testing*

Has anyone in your family had genetic testing? Yes No
 Has anyone in your family been found to have a positive genetic test result (had a cancer predisposition gene mutation found?) Yes No
 Are you interested in genetic testing? Yes No Maybe

4.) *GI Cancer Screening History* (i.e. Colonoscopy, Sigmoidoscopy, Barium Enema, etc.)

A.) Type of screening test/Date: _____
 Where was the test performed (which hospital or Doctor's Office)? _____
 Outcome of the test: _____
 B.) Type of screening test/Date: _____
 Where was the test performed (which hospital or Doctor's Office)? _____
 Outcome of the test: _____
 C.) Type of screening test/Date: _____
 Where was the test performed (which hospital or Doctor's Office)? _____
 Outcome of the test: _____

If you have had more screening tests, please describe in the space provided.

5.) *GI History*

A.) Have you been diagnosed with colon polyps? Yes No
 If yes, about how many were found all together? _____
 When were the polyps first detected? _____
 When were the polyps last detected? _____

B.) Have you ever been diagnosed with (Check all that may apply)?

- | | |
|---|---|
| <input type="checkbox"/> Chronic Ulcerative Colitis | <input type="checkbox"/> Helicobacter Pylori (associated with ulcers) |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Barrett's Esophagus |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Peptic Ulcer Disease | <input type="checkbox"/> Hemochromatosis |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Chronic Pancreatitis |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Acute Pancreatitis |
| <input type="checkbox"/> Hepatitis C | |
| <input type="checkbox"/> Hepatitis, unknown type | |

C.) Have you ever experienced or are currently experiencing the following (Check as many boxes as apply)?

	Currently have this problem	Had it within the past 12 months	Had it more than 12 months ago	Have never had this problem
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you ever had any of the conditions listed above, please explain in the space provided.

6.) For Women Only:

- A.) When was your last mammogram? _____
- B.) When was your last visit to the Gynecologist? _____
- C.) Do you currently have menstrual periods? Yes No
- D.) Are your menstrual periods: Regular
 Usually Regular
 Never Regular

7.) General Health History

- A.) Do you have any general health problems? Yes No
 If yes, please describe:

B.) What medicines are you currently taking?

C.) Do you have any allergies to any medicines? Yes No
If yes, what type of allergies:

D.) Have you had any other surgeries? Yes No
If yes, please explain:

E.) Have you had any surgeries to reduce your cancer risk? Yes No
If yes, please explain:

8.) *Alcohol Intake*

A.) How many drinks per week on average do you have currently? _____
What type of alcohol is it typically (i.e. beer, wine, etc.)? _____
B.) How many drinks per week did you have on average at age 20? _____
What type of alcohol was it typically (i.e. beer, wine, etc.)? _____

9.) *Tobacco History*

A.) Have you ever smoked cigarettes regularly? Yes No
At what age did you start? _____
At what age did you stop? _____

B.) Do you currently smoke cigarettes? Yes No
How many cigarettes on average per day do you smoke? _____

★ Thanks for completing the questionnaire-it will help ensure as thorough an evaluation as possible. Please return this along with the family history questionnaire in the enclosed envelope, or FAX to 215-349-5314 PRIOR to your appointment ★

GI CANCER RISK EVALUATION PROGRAM
REQUEST TO OBTAIN MEDICAL RECORDS

Patients Name: _____

Date of Birth: _____

Hospital Name: _____

Hospital Address: _____

Type of information requested:	Date(s) of Procedures
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<input type="checkbox"/> Colonoscopy report _____	
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<input type="checkbox"/> Pathology report regarding colon polyp(s) _____	
--	--

<input type="checkbox"/> Pathology report and op notes from colon cancer surgery _____	
--	--

<input type="checkbox"/> Pathology report and op notes from ovarian cancer surgery _____	
--	--

<input type="checkbox"/> Pathology report and op notes from hysterectomy _____	
--	--

<input type="checkbox"/> Office note/summaries _____	
--	--

<input type="checkbox"/> MSI results _____	
--	--

<input type="checkbox"/> Genetic testing results _____	
--	--

<input type="checkbox"/> Other _____	
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I give permission to the University of Pennsylvania Medical Center to obtain medical records as indicated above on myself or my family member.

Name (Print) _____ Date _____

Signature _____

Relationship to patient _____

PLEASE SEND ALL RECORDS TO:

Samantha Halter

GI Division

415 Curie Blvd

600 CRB

University of Pennsylvania

Philadelphia, PA 19104

scadieux@mail.med.upenn.edu

P: 215-898-0154

F: 215-573-2024

PLEASE DIRECT ALL QUESTIONS REGARDING THIS REQUEST TO SAMANTHA HALTER @ 215-898-0154

Family History Questionnaire
University of Pennsylvania Medical Center
GI Cancer Risk Evaluation Program

Instructions:

- 1) Please list all your blood relatives, whether or not they have had cancer. If you do not know exact dates, please estimate the year.
- 2) There is a page at the end to list additional relatives. Please indicate how the relatives with cancer are related to you. If there is still not enough room, please list answers to questions on a separate piece of paper.
- 3) You may need to speak with other relatives to increase the accuracy of the information on this questionnaire. We understand that sometimes information is just not available to you.
- 4) If you have any questions about completing the questionnaire, please contact Jill Stopfer, MS, genetic counselor, at 215-349-8143. You can mail the questionnaire back with the enclosed envelope, or FAX it back to 215-573-2024.

NAME _____	Date of Birth _____	
(First) (last) (Middle) (Maiden)		
ADDRESS _____		
(Street)		

(City)	(State)	(ZIP)
Phone (home): () _____	(work) () _____	

You, Your Parents and Grandparents

NAME First, Last and Maiden Name	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location Of Polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, Pancreas, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
You								
Your Mother								
Your Father								
Your Mother's Mother								
Your Mother's Father								
Your Father's Mother								
Your Father's Father								

Your Brothers & Sisters

NAME First, Last and Maiden Name	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Sister 1								
Sister 2								
Sister 3								
Brother 1								
Brother 2								
Brother 3								

Your Children

NAME First, Last and Maiden Name	DATE OF BIRTH	DATE OF DEATH (if applicable)	Any Polyps? Yes or No Location of Polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Daughter 1								
Daughter 2								
Daughter 3								
Son 1								
Son 2								
Son 3								

Your Aunts and Uncles (Mother's side)

NAME First, Last and Maiden Name	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Mother's sister 1								
Mother's sister 2								
Mother's sister 3								
Mother's brother 1								
Mother's brother 2								
Mother's brother 3								

Your Aunts and Uncles (Father's side)

NAME First, Last and Maiden Name	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Father's sister 1								
Father's sister 2								
Father's sister 3								
Father's brother 1								
Father's brother 2								
Father's brother 3								

Cousins (Children of your Mother's brothers and sisters)

NAME First, Last and <u>name</u> <u>of parent</u>	DATE OF BIRTH	DATE OF DEATH (if applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Cousin 1								
Cousin 2								
Cousin 3								
Cousin 4								
Cousin 5								
Cousin 6								
Cousin 7								

Cousins

(Children of your Father's brothers and sisters)

NAME First, Last and <u>name</u> <u>of parent</u>	DATE OF BIRTH	DATE OF DEATH (if applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Cousin 1								
Cousin 2								
Cousin 3								
Cousin 4								
Cousin 5								
Cousin 6								
Cousin 7								

Your Nieces and Nephews (children of your brothers and sisters)

NAME First, Last and <u>Name</u> of Parent	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Niece 1								
Niece 2								
Niece 3								
Nephew 1								
Nephew 2								
Nephew 3								

Additional Relatives with Cancer or Polyps

NAME First, Last and <u>Relationship to you</u>	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Relative 1								
Relative 2								
Relative 3								
Relative 4								
Relative 5								
Relative 6								

Additional Relatives with Cancer or Polyps

NAME First, Last and <u>Relationship to you</u>	DATE OF BIRTH	DATE OF DEATH (If applicable)	Any Polyps? Yes or No Location of polyps	Age when first polyp found Leave blank if no polyps	AFFECTED WITH CANCER? Yes or No	LOCATION OF CANCER (Ex. Breast, Colon, etc.)	YEAR OF CANCER DIAGNOSIS	HOSPITAL WHERE CANCER DIAGNOSED
Relative 7								
Relative 8								
Relative 9								
Relative 10								
Relative 11								
Relative 12								