Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Queen's University

DIVISION OF MEDICAL GENETICS
Familial Oncology Program
Kingston Health Sciences Centre
Armstrong 4, 76 Stuart St,
Kingston, ON K7L 2V7
Tel: (613) 549-6666 ext. 2800
Fax: 613-545-5722

Medical and Family History Questionnaire

IMPORTANT: You were referred to Genetics and are on our wait list for an appointment. This questionnaire provides us with information about you and your family that is important for our assessment. **Please complete this form as soon as possible to prevent any delays to your assessment.**

If you or a relative has been seen for genetic counselling at our clinic or another genetics clinic, please include their name and date of birth (if known) here:

_____

Please return your form as soon as possible. Options for returning your form:

1. Email to fop.genetics@kingstonhsc.ca
2. Fax to 613-545-5722
3. Mail to the Familial Oncology Program (address above)

A fillable PDF version of this form can be found on our website at https://kingstonhsc.ca/medical-genetics/forms-and-links and can be emailed to the email address above.

Name of Patient: _____

Sex Assigned at Birth (IE: Male/Female/Other): _____

Gender Identity (IE: Male/Female/Non-Binary/Other): _____

Preferred Pronouns (IE: He/She/They/Other): _____

Patient's Date of Birth: _____/_____/_____(dd/mm/yyyy)

Person completing form: □ Patient □ Parent □ Other (specify relationship) _____

Tips for Completion:

1. Please reach out to your relatives for details. If you don't have specifics, please fill out as much as you can.

2. Include all biologically related family members, including those that are healthy. It is important for us to know the size of your family as part of the assessment.

3. If you have half-siblings, please note the parent that is shared with you/the patient.

4. For our purposes, the terms "Mother/Maternal" and "Father/Paternal" refers to the persons who contributed the egg and sperm to the pregnancy of the patient. We recognize that those individuals may not in fact be the "Mother" and "Father" of the patient as they define their parents. If you do not know this information, that is fine, please indicate that on this form.

5. If you don't know exact ages, please estimate (IE:. diagnosed in their 50s).

6. If you have too many relatives to fit in the space provided, please write any additional family history on a blank sheet of paper and include it when you return this form.

7. Any information shared with us is covered under the Personal Health Information Privacy Act (PHIPA) and will remain confidential, unless mandated otherwise by the Act or other Acts.

Breast Cancer Risk Assessment Form

(Please complete only if sex assigned at birth is female)

1. How tall are you? _____ feet _____ inches or _____ cm

2. What is your current weight? _____ lb or _____kg

3. Do you drink alcohol? _____ Yes _____ No
   - Glass of Wine (175ml) → daily, weekly, monthly? Amount _____
   - Pint of Beer, Lager, Cider (568ml) → daily, weekly, monthly? Amount _____
   - Bottle of Beer (Standard 330 ml) → daily, weekly, monthly? Amount _____
   - Alcoholic Pop Drink (275 ml) → daily, weekly, monthly? Amount _____
   - Shot of Spirits (25 ml), includes gin, rum, vodka, whisky, tequila, Sambuca → daily, weekly, monthly? Amount _____

4. How old were you when you started your period? _____

5. Have you ever taken the oral contraceptive pill? _____ No _____ Yes
   - For how many years in total? _____
   - Have you taken the pill in the last two years? _____

6. Have you ever had any children? _____ No _____ Yes → At what age did you have your first child? _____

7. Have you ever had your tubes tied (tubal ligation)? _____ No _____ Yes _____ Unknown

8. Have your periods stopped completely for more than 6 months? _____ No _____ Yes → At what age? _____

9. Have you ever used hormone replacement therapy (HRT) for menopause? _____ No _____ Yes
   - How many years in total have you used HRT? _____
   - Have you used HRT in the last five years? _____
   - What is the name of the HRT you have used _____

10. Have you ever been diagnosed with endometriosis? _____ No _____ Yes _____ Unknown

11. Have you ever had both ovaries removed (oophorectomy)? _____ No _____ Yes _____ Unknown

12. Have you ever had both breasts removed (mastectomy)? _____ No _____ Yes _____ Unknown

13. Have you ever had a mammogram? _____ No _____ Yes → Breast density in BIRADS? _____

Are your parents related by blood (IE: cousins or second cousins)?	□ Yes	□ No
Maternal ancestry* ? □ Unknown	**Paternal ancestry*? □ Unknown**	
Do you have any Ashkenazi Jewish ancestry?	□ No	□ Yes , mother/egg donor side □ Yes , father/sperm donor side

*Ancestry in this context refers to either the group or groups that you identify as based on you/your family's origin or background. This can sometimes be captured in a distinct cultural group or may represent the country or countries from which you/your ancestors originated (IE: French Canadian / Indigenous / Ashkenazi Jewish or English / Chinese). Please list as many of these groups that apply to your family. Please note, we are looking for an ancestry other than "Canadian", so if you are unsure, please check the box.

Relative	Name	Sex at Birth	Gender Identity (if different than sex at birth)	Living? Y/N	Age Now or Age at Death (estimate if unsure)	Cancer type and age at diagnosis
Example	*Robin Lee*	*F*		*N*	*65y*	*Breast Cancer dx at 64*
Your Biological Children □ None						
Full Siblings (brothers and sisters with the same mom & dad as you) □ None						
Maternal Half siblings (same mother/egg donor) □ None						
Paternal Half siblings (same father/sperm donor) □ None						

Maternal Side						
Relative	**Name**	**Sex at Birth**	**Gender Identity (If different than sex at birth)**	**Living? Y/N**	**Age Now or Age at Death (estimate if unsure)**	**Cancer type and age at diagnosis**
Mother/egg donor						
Grandmother						
Grandfather						
Aunts and Uncles (If half siblings to parents, please list M=mat, P=pat) □ None						

Paternal Side						
Relative	**Name**	**Sex at Birth**	**Gender Identity (If different than sex at birth)**	**Living? Y/N**	**Age Now or Age at Death (estimate if unsure)**	**Cancer type and age at diagnosis**
Father/sperm donor						
Grandmother						
Grandfather						
Aunts and Uncles (If half siblings to parents, please list M=mat, P=pat) □ None						

Extended Family Members with Related Health and/or Developmental Concerns							
Relative		**Relationship Notes**	**Side of Family (mat / pat)**	**Sex at Birth**	**Gender Identity**	**Living? (Y/N)**	**Cancer type and age at diagnosis**
Examples	*Cousin*	*Child of Mary Smith*	*Mat*	*F*	*F*	*Y*	
	Great-grandma	*Maternal grandma's mother*	*Mat*	*F*	*F*	*N*	

What are some of the concerns/questions you would like addressed/answered at your visit to the Genetics clinic?	
Has anyone in your family ever had genetic testing? If so, please provide a copy of the report or anything available to you (such as where testing was completed).	
If there is any other relevant information you think we should know, please tell us here.	

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REQUEST FOR EMAIL CONSENT

We may use email to communicate with you about your care, and some appointments may be virtual. In order for us to communicate with you via email, KHSC requires written consent from you. The forms on the following pages provide you with information about how your information is being collected and used electronically.

Please complete the following forms as soon as possible. We may not book an appointment until this has been completed. If you wish to decline communicating via email, please reach out to us to inform us of your decision.

You may also complete this form electronically using the QR code below. **If you use the QR code, please let us know once this has been completed.**

KINGSTON HEALTH SCIENCES CENTRE
PATIENT CONSENT FOR ELECTRONIC COMMUNICATION

You are filling out this form because you want to communicate with KHSC agents (acting on behalf of the hospital) about your care (including payment for delivery of your healthcare), or about someone else's care that you are acting on behalf of. The personal health information that you provide below is being collected, used, and disclosed under the *Personal Health Information Protection Act* (Ontario), 2004 for the purposes of providing care to the patient and to verify the patient's/your identity. If you have any questions about your privacy or the information being collected in this form, please contact KHSC's Privacy Office by email at privacy@kingstonhsc.ca or by phone at (613) 549-6666 extension 2567.

Patient's First Name:	
Patient's Middle Name(s):	
Patient's Last Name:	
Patient's Date of Birth (MM/DD/YYYY):	____ /____ /_____
Patient's Health Card Number, including version code:	
Email address to be used to communicate:	

Please indicate if you are:

☐ 1. Consent on your own behalf as the patient

☐ 2. Consenting on behalf of the patient as their Substitute Decision Maker (SDM)

☐ 3. Consenting on behalf of the patient as their Family Member/Alternate

If you choose option 2 (SDM) or 3 (Family Member/Alternate) above, please provide the following information:

Your First Name:	
Your Last Name:	
Your Relationship to the Patient:	
Your Phone Number:	

Q: Is my contact information used or shared for other purposes?

A: Your contact information may be shared with those who need it to provide you with health care. Your health care teams needs access in order to plan and deliver your health care. This may include sharing your contact information with:

- Other approved health information organizations or providers (e.g. Community Care Access Centre, family physicians, community mental health)
- eHealth Ontario provincial electronic health record and other regional health information repositories (e.g. South East Health Integration Information Portal SHIIP)
- Other allied health care professionals who will provide your follow-up care

We may also use or share your contact information to:

- Perform activities to improve and maintain the quality of the care that we deliver to you;
- Conduct risk management activities;
- Teach health care professionals (we use de-identified information where possible);
- Plan, administer and manage our internal operations;
- Obtain payment for delivery of your health care (e.g. from OHIP, WSIB or others);
- Fund-raise to improve our health care services and programs (information limited to name and address);
- To conduct research;
- Comply with legal and regulatory requirements.

At any time you may withdraw your consent to communication using electronic means or to share your personal health information for research, fundraising or patient satisfaction surveys. To do so, please contact KHSC's Privacy Office at:

Privacy and Freedom of Information Office
Kingston Health Sciences Centre
76 Stuart Street
Kingston, ON K7L 2V7
Phone: (613) 549-6666 or 1-800-567-5722 Ext. 2567
Fax (613) 548- 2445
Email: privacy@kingstonHSC.ca

☐ I wish to communicate electronically about my (or the patient's) personal health information. I understand the risks, benefits and limitations outlined below.

Signature of Patient:		Date: (MM/DD/YYYY)	____ /____ /_____
Signature of Substitute Decision Maker/Family Member/Alternate:		Date: (MM/DD/YYYY)	____ /____ /_____

For Institution Use Only

☐ **Email address entered into Patient Care System (PCS)**

Staff Signature:_____ **Printed Name:**_____ **Designation:**_____ **Date:**_____ **Time:**_____
yyyy/mm/dd hhmm

Patient Consent for Electronic Communications
Risk & Benefit Disclaimer

- All agents of the hospital may use the information you provide to communicate with you as outlined in this consent form. Please make sure your email account is private and your health care provider may send sensitive information to the address you've provided.
- Electronic communications may not be encrypted outside of the hospital email system, and security and privacy can never be completely guaranteed.
- Communications can be forwarded, intercepted, stored or even changed without the knowledge or permission of the health care provider or patient. Communications may be misdirected, resulting in it being sent to many unintended or unknown recipients.
- Even when communications are deleted, back-up copies may exist indefinitely. Electronic communication is a more permanent form of communication compared to verbal communication, either in person or by phone.
- Electronic communications are easier to falsify than handwritten or signed hardcopies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the communication once it has been sent.
- Be aware that communications can introduce viruses into a computer system. Your care provider may choose not to open a communication if the sender is not recognized or may choose not to receive a communication if it looks like it may have a virus attached to it.
- Electronic communications can be delayed for technical reasons beyond the control of your care provider. There may also be a delay between when your care provider receives your email and when they are able to respond. **For these reasons, do not use electronic communications to communicate emergency or urgent health matters. Call 911 or attend to local emergency department in those circumstances.** Electronic communications must not be used as a substitute for regular clinical examination.
- Always consider the sensitivity of the content and inherent risks before sending. Please tell your care provider if there are certain types of information you do not wish to discuss by electronic communication.
- You understand that KHSC and on-line services (e.g. Gmail) have a legal right to inspect and keep communications that pass through their system.
- Your care provider may make decisions about your treatment based on information you provide by electronic communications. In this case, your communications will become part of your patient record and as such may be used as evidence in court.
- At any time, you or your care provider can decide that you no longer wish to use electronic communications. If you decide to stop communicating electronically, you must inform your care provider in writing or at your next appointment. You will be asked to sign a "Revoking Consent for Electronic Communications" form which will cancel your consent to use electronic communications with your care provider.
- If your care provider cannot continue to use electronic communications with you, they will inform you in writing and/or notify you about this at the time of your next appointment.
- It is your responsibility to follow-up to determine whether the intended recipient received the email/text message and that the recipient has responded.
- It is your responsibility to ensure the hospital retains the correct email address/phone number.
- For questions about email/text message communications, please speak to your care provider.