OKLAHOMA
CANCER SPECIALISTS
AND RESEARCH INSTITUTE

Name _____ Date of Birth _____

You are being referred to Oklahoma Cancer Specialists and Research Institute for Cascade testing.

Cascade testing is the performance of genetic risk counseling and testing in blood relatives of individuals who have been identified with specific genetic mutations. Cascade testing may include screening, risk counseling, or referral for a patient with a relative who has tested positive for a genetic mutation.

For us to facilitate your referral we ask that you please complete the attached Patient forms required to start building your chart. Please fax these with a copy of your insurance cards to 918-592-3809 using this letter as the cover sheet to ensure your referral will be directed to our Genetic Risk Counseling department.

If you do not have availability to fax, you may return this information to our front desk at OCSRI and they will forwarded this on to our Intake department.

We look forward to serving you.

Thank you

OCSRI
12697 E 51st St S
Tulsa, OK 74146
(918) 505-3200

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Patient ID: _____

Patient Name: _____
First *Middle* *Last* Sex:

Date of Birth: _____ Age: _____ SSN: _____

Language: _____ Race: _____ Ethnicity: _____

Marital Status: _____ Home #: _____ Cell #: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Patient Employer: _____ Occupation: _____

Do you have an Advanced Directive? (Examples: DNR, Living Will, Power of Attorney):

☐ Yes, on File ☐ Yes, I will bring a copy ☐ No, would like more information ☐ No, not interested at this time

Primary Ins Name: _____

Policy Holder Name: _____

Relationship to Policy Holder: _____

ID #: _____ Group #: _____ Subscriber DOB: _____

Secondary Ins Name: _____

Policy Holder Name: _____

Relationship to Policy Holder: _____

ID #: _____ Group #: _____ Subscriber DOB: _____

☐ I would like to receive text message reminders (Standard text rate messaging and data rates will apply)

I assign and authorize payment for any & all services rendered to OCSRI from my insurance company or third-party payor. I agree to pay all charges not covered by my insurance including but not limited to deductibles, co-payments, and non-covered services. I hereby authorize release of pertinent information to my insurance carrier(s). This order will remain in effect until revoked by me in writing.

Signature: _____ Date: _____

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

FINANCIAL POLICY

Thank you for choosing Oklahoma Cancer Specialists and Research Institute (OCSRI) for your medical care. We look forward to serving your needs. We want you to be an informed participant in your medical care. Therefore, we have summarized our financial policy for you in order for you to be aware of our expectations regarding your financial obligations to OCSRI.

If OCSRI has a contract with your insurance company, we will be happy to bill your insurance company for you after verification of your coverage benefits. Your coverage benefits include eligibility, service coverage, deductibles, co-insurance percentage, and copay amounts. **All patients are required to bring their insurance cards with the policy ID number and insurance company phone number. If you do not have your insurance card and/or we cannot confirm coverage, you will be required to pay in full at time of service.** Patients are expected to pay in full any applicable co-pays, deductible and/or co-insurance expense at the time services are rendered in our office. If we are unable to determine your financial responsibility at the time of service, payment is due **IN FULL** as balances are incurred. Based on the contract in place with your insurance company, we are required to collect your co-pays, deductible, and co-insurance. These balances cannot be waived.

OCSRI will make every reasonable effort to collect payments due from your insurance company. However, you are ultimately responsible for all services rendered, as well as assuring timely payment from your insurance company. We recommend you follow-up with your insurance company on any outstanding balance you may have with OCSRI. You will be liable for any service considered not medically necessary or cosmetic by your insurance company as well as all non-covered or reimbursed services. We will inform you if any of your services have the potential to fall within these category. In the event of non-payment, you will assume the cost of interest, collection and legal action (if required).

OCSRI will review your benefits at the time of services rendered to best gauge your personal liability. All quotes given by OCSRI are estimates based on the plan information available to us at the time of review. These estimates are not a guarantee of maximum liability and we encourage you to reach out to your insurance plans to obtain a clear understanding of how your co-pays, deductibles, and out of pocket expenses may apply to the services you are receiving.

OCSRI accepts Medicare assignment. If you do not have secondary insurance coverage, we are required by law to collect the 20% co-insurance of the Medicare allowable. We are also required to collect the annual Medicare deductible, if you have not met your deductible prior to your appointment. Medicare only pays for services they deem medically necessary. We will inform you if any of your services have the potential to fall outside of this category, as you are responsible for payment of all non-covered services at the time of service.

Some of your laboratory tests, biopsies, cultures, radiological services obtained by the physician during your appointment, may be sent to an outside provider and will not be part of your office services at OCSRI. You will receive a separate bill from the outside provider. OCSRI is not obligated to pay for these service in anyway, covered or non-covered by your insurance company.

OCSRI is happy to offer the following payment options:

- Cash, checks, Visa, MasterCard, American Express, and Discover. We cannot accept personal third party checks or post-dated checks
- Payment plans at various interest rates with approved application

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Your right to payment for all drugs, procedures, test, equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to OCSRI. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurances and any other health plans. You acknowledge this document as a legally binding assignment/agreement to collect my benefits as payment representative; you will endorse such payments to OCSRI.

I authorize my insurance carrier(s) to release information regarding my coverage to Oklahoma Cancer Specialists and Research Institute

*If I request to apply for a payment plan, I understand Oklahoma Cancer Specialists and Research Institute will inquire into my credit history through a credit reporting agency. I understand that this information will solely be used for the purpose intended and will NOT be released to any outside agency.

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PATIENT RIGHTS

As a patient, I have the right to:

- Full information about my rights and responsibilities as a patient in a physician's office.
- Receive in terms I can understand:
  - An explanation of my medical condition.
  - The benefits and risks of the treatments my doctor recommends.
  - Alternatives to that treatment.
  - An understanding of the consequences if I choose not to undergo recommended treatment.
- An explanation of all rules, regulations and services provided by the doctor's office, including the days and hours of service and how to reach a physician after regular office hours.
- Choose my own physician and be informed of the names, areas of responsibility and experience of the staff.
- Participate in developing my Plan of Care including an Advance Directive.
- Participate, or refuse to participate, in any research study or aspect of care including investigational studies and freely withdraw previously given consent for further treatment.
- Full financial explanation and payment schedules prior to beginning any treatment.
- Receive expert, professional care without discrimination regardless of race, creed, color, religion, national origin, handicap, sexual preference, sex or age.
- Be treated with courtesy, dignity and respect of my personal privacy by all practice employees.
- Complain or file grievance with the Practice Administrator without fear of retaliation or discrimination.
- Confidential treatment of my condition, medical record and financial information.
- Obtain copies of my personal records upon my request.

PATIENT RESPONSIBILITIES

As a patient, I have the responsibility to:

- Provide accurate and complete information related to my physical condition, hospitalizations, medications, allergies, medical history and related items.
- Provide new or changed information related to my health insurance to the practice business office and be prepared to meet my co-pay requirements during office visits.
- Treat physicians, advanced practitioners, staff and other patients with courtesy, dignity and respect regardless of race, creed, color, religion, national origin, handicap, sexual preference, gender or age. Inappropriate, discriminatory or derogatory comments will not be permitted.
- Refrain from aggressive or threatening behavior -verbal or physical. Disruptive acts or hostile behavior toward staff, licensed practitioners, or other patients or visitors will not be tolerated.
- Contact the office in advance when unable to keep a scheduled appointment.
- Request more detailed explanations for any aspect of service I do not understand.
- Inform my physician or nurse of any changes in my condition or any new problems or concerns.
- Inform my physician or nurse about prescription refill needs before my supply is gone.
- Communicate any change in my address or telephone number to the practice business office.
- Participate and cooperate in my Plan Of Care, Advance Directive and Living Will.

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

PATIENT AGREEMENT

DISCLOSURE OF INFORMATION

I understand that my medical and billing records are maintained by Oklahoma Cancer Specialists and Research Institute (OCSRI) and are accessible to personnel. OCSRI personnel may use and disclose medical information for treatment, payment or operations to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. OCSRI and it's personnel are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the services rendered. Oklahoma law requires OCSRI to advise you that the **information authorized for use or disclosure may include information which may indicate the presences of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse.** By signing this agreement, you are consenting to such disclosure. _____
initial

ASSIGNMENT OF INSURANCE BENEFITS

My rights to payment for all drugs, procedures, tests, equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to OCSRI. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurances and any other health plans. I acknowledge this document as a legally binding assignment/agreement to collect my benefits as payment representative; I will endorse such payments to OCSRI. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit care at the time of service. _____
initial

FINANCIAL RESPONSIBIILITY

I acknowledge I have received, understand and agree to the terms listed in the OCSRI's Financial Policy. _____
initial

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have received, read and understand my Patient Rights and Responsibilities. _____
initial

CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient, or Legal Representative for the patient, and I accept the terms of this patient Agreement. A photocopy of this document has the same effect as an original.

Signature: _____ **Relationship to Patient:** _____
(if applicable)

Printed Name: _____ **Account Number:** _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by OCSRI is in our **NOTICE OF PRIVACY PRACTICES**, which you have received.

I have received a copy of the **Notice of Privacy Practices**.

Signature: _____ **Relationship to Patient:** _____ **Date:** _____
(if applicable)

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS OR FRIENDS

Many of our patients allow family members and friends to call and request information related to appointments, medical, prescriptions or billing. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have this type of information released, including prescription pick-up, this form must be signed. Signing this form will only give consent to release this information to the family members or friends indicated below. This authorization shall be in force and effective for the duration of 12 months from date of signature, at which time this authorization will expire.

You have the right to revoke this consent in writing.

I authorize/allow Oklahoma Cancer Specialists and Research Institute to release my information to the following individual(s):

_____ Relation to Patient _____ Phone _____

_____ Relation to Patient _____ Phone _____

_____ Relation to Patient _____ Phone _____

II. ACKNOWLEDGEMENTS AND SIGNATURES

A. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

B. I understand if the person/organization authorized to receive my protected health information is not a health plan or health care provider, privacy regulations may no longer protect the information.

C. I understand I may inspect or obtain a copy of the protected health information shared under this authorization by sending a written request to Oklahoma Cancer Specialists and Research Institute.

D. I acknowledge information authorized for release may include records, which may indicate the presence of a communicable or non-communicable disease.

E. Right to Revoke – I understand I may change this authorization at any time by writing to Oklahoma Cancer Specialists and Research Institute. I understand I cannot restrict information that may have already been shared based on this authorization.

F. This document must be signed by the patient or the patient's legal representative.

Patient or Legal Representative

Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____
(if applicable)

Account Number: _____

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003
Revised: February 23, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Federal Government's Health Insurance Portability and Accountability Act (HIPAA) require covered health care providers to issue a Privacy Notice to their patients. This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected.

Oklahoma Cancer Specialists and Research Institute (OCSRI) understands that your health information is personal, and we are committed to protecting your privacy and ensuring that your health information is not used inappropriately. We will abide by the terms of this Notice.

HOW THE COMPANY MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

We use an electronic medical record. This is a computer system that allows OCSRI providers and other providers that are not related to us to read and add health information about you.

The following categories describe some of the ways that OCSRI may use and disclose your health information.

Treatment: We may use your health information to provide you with medical treatment or services. *Example:* Your health information will be disclosed to the oncology nurses who participate in your care. We may also disclose your health information to other health care providers involved in your care to ensure those parties have all the information necessary to help diagnose and treat you.

We may share your health information with pharmaceutical company patient assistance programs and patient support organizations in order to assist you in obtaining financial and non-financial support for your care.

Payment: We may use your health information for payment activities, including but not limited to, determining plan coverage, billing/collection, and assisting another health care provider with payment activities. *Example*: Your health information may be released to an insurance company to obtain pre-approval of services or payment for services.

Health Care Operations: We may use and disclose your health information to support our health care operations. *Example:* Your health information may be used for quality assessment/improvement activities or conduct internal audits to verify proper billing procedures.

Research: We may use and disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Business Associates: We may disclose your health information to other individuals or companies that provide a service to or on OCSRI's behalf. Your health information will be released only if we have received satisfactory assurance through a written agreement that these entities will properly safeguard your information. *Example:* Your health information may be released to business associates involved in billing or transcription services.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be of interest to you. *Example:* We may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Appointment Reminders: We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services.

Individuals Involved in Your Care or Payment for Your Care: We may release your health information to a family member, friend, or legal guardian who is involved in your care or who helps pay for your care unless you asked us not to. If you are unable to agree or object to these disclosures, our health care professionals will use their best judgment in communicating with your family and others.

YOUR HEALTH INFORMATION RIGHTS

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes or information that is compiled in reasonable anticipation of, or use in, a civil, criminal, and administrative action or proceeding. You must make your request in writing by filling out the appropriate form provided by us. We may charge you for health records in a paper or digital format and cost of mailing in accordance with state and/or federal laws.

Right to Request Changes: You have the right to identify and request changes or additions to your health information when you believe information is incorrect or incomplete. It is up to your provider whether or not the requested change or addition will be made to the health record. However, your written request for changes or additions will remain with your health record.

Right to a Copy of This Notice: You have the right to receive a copy of this Notice electronically or obtain a paper copy of the Notice from us upon request. The Notice is posted and available at each of OCSRI's location(s) and on our website.

Right to Accounting of Disclosures: You have the right to request a free list of certain disclosures every 12 months. We are not required to list all disclosures, such as those authorized or made for treatment, payment, or operations. Your request must state a time period which may not be longer than six years, and which may not include dates before April 14, 2003. If you request more than one accounting in a 12 month period, we may charge you for the cost of the list. We will notify you of the costs involved and give you an opportunity to withdraw or modify your request before any costs have been incurred.

Right to Request Confidential Contacts: You have the right to request that OCSRI contact you about medical issues in a certain way or place, such as by mail. You must specify how or where you want to be contacted. We will attempt to accommodate all reasonable requests.

Right to Request Restrictions: You have a right to request a limit on the medical information released to others involved in your care or the payment of your care. Your provider has the right to deny the request, but must provide you with a reason if it cannot be met. You may request to restrict disclosure of protected health information to a health plan if the healthcare item or service is paid out of pocket in full at time of delivery.

Right to Be Informed About Privacy and Security Breaches: You have the right to expect that we will hold staff responsible for any improper access, use, or release of your health information. You have the right to expect that if your protected health information has been compromised, we will investigate the breach as required by law and you will be notified and assisted accordingly.

USES AND DISCLOSURES OF HEALTH INFORMATION REQUIRED OR PERMITTED BY LAW

The following categories describe some of the ways that OCSRI may be allowed or required to use and disclose your health information without your consent or agreement.

Law Enforcement: We may disclose your protected health information if required by federal, state, or local law, such as when required by a court order, cases involving felony, or to the extent an individual is in the custody of law enforcement.

Food and Drug Administration (FDA): We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Public Health and Safety/Serious Threat: We may use and disclose your health information to public health or legal authorities charged with preventing or controlling disease, abuse or neglect, disaster relief assistance, and averting a serious threat to the health and safety of a person or the public.

Coroners, Medical Examiners, and Funeral Directors: We may release your health information to a coroner or funeral director as necessary for them to carry out their duties.

Organ/Tissue Donation: Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

Workers' Compensation: We may disclose your health information to the extent necessary to comply with laws relating to Workers Compensation.

Specialized Government Functions: We may disclose your health information to national security agencies for the protection of persons or to conduct special investigations. If you are in the armed forces or reserves, your health information may be disclosed to military authorities.

Correctional Institutions: If you are an inmate of a correctional institution, we may disclose to the institution or its agents the health information necessary for your health and the health and safety of other individuals.

OTHER INFORMATION TO KNOW

Oklahoma law requires that OCSRI inform you that your health information used or disclosed as described in this Notice may include information which may indicate the presence of a communicable disease or non-communicable disease. It may also include information related to mental health.

Other uses and disclosures of your health information for a purpose not described in this Notice or required/permitted by law, *we must obtain a specific authorization from you for that use or disclosure, and you may revoke that authorization at any time.* Examples of specific authorizations may include most uses and disclosures of psychotherapy notes, marketing disclosures and sale of protected health information. We will not use or disclose your health information for fundraising activities.

OCSRI reserves the right to amend, change, or eliminate provisions in our Notice and to enact new provisions regarding the health information created, received and maintained about you. Revised Notices will be posted and available by request at OCSRI's location(s) and on our website.

If you have questions, would like additional information, or want to report a problem regarding your privacy rights, you may contact the Compliance Coordinator at 918-499-2115. You may also file a complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights. You will not be retaliated against for filing a complaint.

Personal and Family History Questionnaire
Genetic Evaluation
Oklahoma Cancer Specialists and Research Institute
12697 E. 51st Street
Tulsa, OK 74146
Phone: 918-505-3200

Please fill out and return this form by mail in the addressed/stamped envelope (Medical records 12697 E. 51st Street, Tulsa, OK, 74146) no later than the Friday before your appointment date. Or fax to 918-592-3809.

If this form is not mailed a week before your appointment, please call 918-505-3200 to reschedule.

Date:_____

Name: _____ Date of Birth:_____

Referring Healthcare Provider:_____

Reason for referral: _____

Gender at birth: Female ☐ Male ☐ Gender identity: Female ☐ Male ☐ Transgender ☐ _____

Are you adopted? YES ☐ NO ☐ Are you a twin? YES ☐ NO ☐ if yes -are you identical ☐ or fraternal ☐ ?

Ancestry: **Please select all that apply**

Mother's Side

☐ Western/Northern European ☐ Jewish
☐ Central/Eastern European ☐ African
☐ Middle Eastern ☐ Asian
☐ Latin American/Caribbean ☐ Native American

Father's Side

☐ Western/Northern European ☐ Jewish
☐ Central/Eastern European ☐ African
☐ Middle Eastern ☐ Asian
☐ Latin American/Caribbean ☐ Native American

Please list any *hereditary cancer genetic testing* you or your family members have had.
If a family member has previously been tested, please obtain a copy of their results. A copy of results will be needed in order for you to proceed with testing for any known mutation in the family. It is helpful to obtain all family members genetic reports even if negative:

_____

_____

Note: If you have death certificates or pathology reports on family members with cancer or pre-cancer, please include with packet

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Personal and Family History Questionnaire
Genetic Evaluation
12697 E. 51st Street
Tulsa, OK 74146
Phone: 918-505-3200

Your Personal Health History

Cancer history:

- Do you have a current or past diagnosis of cancer? YES □ NO □

If the answer is yes, please answer these questions, if no then proceed to endoscopy history.

What type of cancer?_____

What age were you when you were diagnosed?_____

What treatments did you receive for this cancer? (surgery, radiation, chemotherapy, hormonal)

_____

_ Have you ever had any other cancers, either current or past? YES □ NO □

Please list type and age(s) at diagnosis:

_____

_____

Endoscopy history:

- Have you ever had a colonoscopy? YES □ NO □
- Age at first colonoscopy _____ Date of last colonoscopy_____

Have you ever had Colon Polyps? YES □ NO □

Age at first colon Polyp _____ Total Number of colon Polyps _____

Type of Polyp (If known) _____

Have you ever had an upper endoscopy? YES □ NO □

Habits/Social history

Have you ever smoked? YES □ NO □. If Yes, How many packs per day_____

Age started_____ Age stopped_____

Do you drink alcohol? YES □ NO □. If Yes, How many drinks per week? _____

Occupation:_____ Retired? YES □ NO □

Relationships: Single □ Significant other □ Partnered □ Married □ Other:_____

For Women:

Age periods started? _____Age at Menopause? _____ Check one: Surgical □ Cancer treatment □ Natural □

#of pregnancies_____ #of live births_____ Number of C-sections _____

At what age did you have your first child? _____ Did you breast feed for longer than 1 month? YES □ NO □

History of abnormal pap smears? YES □ NO □ Age if yes _____

Have you ever taken hormones for menopause? YES □ NO □ Type _____ How long? _____

Have you ever taken oral contraceptives? YES □ NO □ Total # years taken _____

Date (Month/Year) of most recent mammogram _____

Have you ever had a breast biopsy? YES □ NO □ # of biopsies_____

Was your biopsy normal or abnormal? _____Check here if Unknown _____

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Personal and Family History Questionnaire
Genetic Evaluation
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1. Please List surgeries and year surgery completed:

Surgery	Year of surgery

2. Please list any medical history

Condition	Year diagnosed

3. Please list any allergies to medications:

_____

4. Please list medications:

Medication	Dosage	Frequency

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Personal and Family History Questionnaire
Genetic Evaluation
12697 E. 51st Street
Tulsa, OK 74146
Phone: 918-505-3200

This next section is about your PARENTS and GRANDPARENTS - please list all biological relatives including relatives without a history of cancer

Parents and Grandparents	First Name	Living? Check one	Cancer YES NO check one Type: list type if Yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Mother		YES ☐ NO ☐	YES ☐ NO ☐ Type:		
Your Mother's Mother		YES ☐ NO ☐	YES ☐ NO ☐ Type:		
Your Mother's Father		YES ☐ NO ☐	YES ☐ NO ☐ Type:		
Father		YES ☐ NO ☐	YES ☐ NO ☐ Type:		
Your Father's Mother		YES ☐ NO ☐	YES ☐ NO ☐ Type:		
Your Father's Father		YES ☐ NO ☐	YES ☐ NO ☐ Type:		

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Personal and Family History Questionnaire
Genetic Evaluation

12697 E. 51st Street
Tulsa, OK 74146
Phone: 918-505-3200

This next section is about your CHILDREN- please list all biological children including those without a history of cancer

Please indicate if any of your children are twins. Please note if they are identical twins or fraternal twins. If your child is adopted, please specify if they are related to someone else in the family.

Your Biological Children	First Name	Living? Check one	Cancer YES NO check one Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And #daughters Your child has -Use 0 if none
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:
Check one Son ☐ Daughter ☐		YES ☐ NO ☐	YES ☐ NO ☐ Type:			Sons: Daughters:

OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

Personal and Family History Questionnaire
Genetic Evaluation
12697 E. 51st Street
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Phone: 918-505-3200

This next section is about your SIBLINGS - please list all biological siblings including those without a history of cancer

Your Siblings: How many full sisters _____ How many full brothers______
How many half- sisters______ How many half -brothers _____
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, check shared parent	Check gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased	List # sons And # daughters each sibling has -Use 0 if none
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:

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This next section is about your MOTHER'S SIBLINGS - please list all biological aunts and uncles including those without a history of cancer

Your Mother's siblings:
How many full sisters ___________ and brothers ___________ does your mother have?
How many half- sisters______ How many half -brothers _____
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, check shared parent	Check gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters each relative has. -Use 0 if none
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:

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List **your *first* Cousins** on your **MOTHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer**.

Check gender and write first Name of each	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		

Add any additional maternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known

Check gender and write first Name of each	How are they related to you? (Ex: Mother's maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		

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This next section is about your FATHER'S SIBLINGS - please list ALL biological aunts and uncles including those without a history of cancer

Your father's siblings:
How many full sisters ___________ and brothers ___________ does your father have?
How many half- sisters_______ How many half -brothers ______
Please indicate if any siblings are twins. And if twins, note if they are identical.

Please select full or half sib and if half sib, check shared parent	Check gender and write first Name of each sibling	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer diagnosed	Age if living or Age at death if deceased	List # sons And # daughters Each relative has. -Use 0 if none
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:
□ Full □ Half: If half sib, check shared parent Mother □ Father □	Male □ Female □ First name:	YES □ NO □	YES □ NO □ Type:			Sons: Daughters:

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List **your *first* Cousins** on your **FATHER'S** side with cancer: please specify parent of cousin by first name. **Please only list those with a history of cancer**.

Check gender and write first Name of each	Who is their parent (Ex: Uncle Joe)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		

Add any additional paternal family members with a history of cancer: such as great aunts, great uncles, great grandparents, second cousins etc. if known

Check gender and write first Name of each	How are they related to you? (Ex: fathers, maternal great aunt Jane's son)	Living? YES/NO	Cancer: YES NO Type: list type if yes	Age cancer Diagnosed	Current age if living or Age at death if deceased
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		
Male □ Female □ First name:		YES □ NO □	YES □ NO □ Type:		