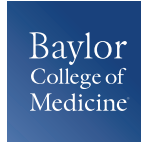




**The Children's Hospital  
of San Antonio™**

**CHRISTUS Health**



**Cancer Genetics Clinic**

Everything for our children.™

Patient Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Thank you for choosing the Cancer Genetics Clinic at The Children's Hospital of San Antonio.

Your appointment is scheduled with Dr. Voeller on \_\_\_\_\_ at \_\_\_\_\_ a.m./p.m.

The clinic is located on the 7th floor, outpatient hematology/oncology clinic, in the main hospital at 333 North Santa Rosa Street, San Antonio, Texas 78207.

Your first visit will take approximately 1.5 to 2 hours because the evaluation requires detailed information about the patient's medical history, developmental history, and family health history. It would also be very helpful if you would collect information about cancer-related history on both sides of the patient's family. Please complete the enclosed forms and bring them with you to your child's appointment.

If your child has been seen by a genetics or oncology doctor before, or if any genetic or other tests (chromosomes, DNA, metabolic, X-ray, CT, or MRI tests) have been done previously, please send those prior to your appointment and/or bring them with you to the visit.

If you cannot come to this appointment or need to reschedule, please call 210.704.2187.

We are looking forward to meeting you and your family in the Cancer Genetics Screening Clinic.

Sincerely,

Cancer Genetics Clinic Faculty and Staff

The Children's Hospital of San Antonio

333 N. Santa Rosa Street

San Antonio, Texas 78207

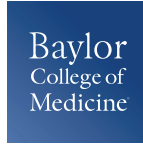
Phone: 210.704.2187

Fax: 210.704.3566



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## Patient Information

Patient name: \_\_\_\_\_

Date of birth (mm/dd/yyyy): \_\_\_\_\_

Name of person filling out form: \_\_\_\_\_

Relationship to child (mother, father, etc.): \_\_\_\_\_

Primary care physician: \_\_\_\_\_

## Birth History

Mother's age at delivery: \_\_\_\_\_ years      Father's age at delivery: \_\_\_\_\_ years

What number pregnancy was this for mother (1st, 2nd, 3rd, etc.)? \_\_\_\_\_

Number of living children \_\_\_\_\_      Number of pregnancy losses \_\_\_\_\_

How many weeks was child born at? \_\_\_\_\_ weeks       Vaginal     C-Section

Any problems during pregnancy, delivery, or post-natal period?

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## Past Medical History

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## Developmental History

Are there any concerns about your child's growth or development?

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## Family History

Please list any history of cancer in the immediate family, such as: bone cancer, brain cancer, breast cancer, colon or other gastrointestinal cancer, kidney cancer, leukemia, liver cancer, lung cancer, muscle cancer, ovarian or uterine cancer, prostate cancer, skin cancer, thyroid cancer, etc. Please include patient's mother, father, and siblings, as well as grandparents, aunts, and uncles on both sides of the family.

Relationship to patient	Male/ Female	<b>B</b> - Share same mother and father as the patient <b>M</b> - Same mother, different father as patient <b>F</b> - Share same father different mother as patient	Still Living? (Y/N)	Diagnosis	Age at Diagnosis
Mother	F	N/A			
Father	M	N/A			
Sibling					
Sibling					
Sibling					
Sibling					
<b>CHILD'S FATHER'S SIDE OF THE FAMILY</b>					
Paternal Grandmother	F	N/A			
Paternal Grandfather	M	N/A			
Paternal Aunt/Uncle					
Paternal Aunt/Uncle					
Paternal Aunt/Uncle					
<b>CHILD'S MOTHER'S SIDE OF THE FAMILY</b>					
Maternal Grandmother	F	N/A			
Maternal Grandfather	M	N/A			
Maternal Aunt/Uncle					
Maternal Aunt/Uncle					
Maternal Aunt/Uncle					