The Children's Hospital of San Antonio™
CHRISTUS Health
Everything for our children.™

Baylor College of Medicine

Cancer Genetics Clinic

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?

_____

_____

_____

Past Medical History

_____

_____

_____

Developmental History

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

_____

_____

_____

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 -** Share same mother and father as the patient **M -** Same mother, different father as patient **F -** 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					
CHILD'S FATHER'S SIDE OF THE FAMILY					
Paternal Grandmother	F	N/A			
Paternal Grandfather	M	N/A			
Paternal Aunt/Uncle					
Paternal Aunt/Uncle					
Paternal Aunt/Uncle					
CHILD'S MOTHER'S SIDE OF THE FAMILY					
Maternal Grandmother	F	N/A			
Maternal Grandfather	M	N/A			
Maternal Aunt/Uncle					
Maternal Aunt/Uncle					
Maternal Aunt/Uncle					