

NWTS LATE EFFECTS STUDY FAMILY AND MEDICAL HISTORY FORM

Participant Name: _____

Patient ID #: _____

Birth Date: _____

Last 4 Digits of Social Security # (Optional): _____

I. PARENT DATA

FATHER (OR GUARDIAN 1)

MOTHER (OR GUARDIAN 2)

1. Biological Parent? (circle one)	1. YES NO	1.	1. YES NO
2. Name (include maiden name)	2. _____	2.	_____
3. Birth Date	3. _____	3.	_____
4. Last 4 Digits of Social Security # (Optional)	4. _____	4.	_____
5. Current Address	5. _____	5.	_____
	(Street)		(Street)
	_____		_____
	(City, State, Zip Code)		(City, State, Zip Code)
6. Phone Number	6. () _____	6.	() _____
7. Current Employer	7. _____	7.	_____
	(Name and type of business)		(Name and type of business)
	_____		_____
	(Phone Number)		(Phone Number)
8. Serious Illnesses	8. _____	8.	_____
	_____		_____
9. Deceased? (Cause/Date)	9. _____	9.	_____

II. NWTS PARTICIPANT'S MEDICAL HISTORY:

Since completion of treatment for Wilms tumor please report serious illnesses, hospitalizations, and second tumors if not previously reported to NWTS.

Date	Diagnosis	Hospital(City/State)	Physician	Treatment/Outcome
1.				
2.				
3.				
4.				
5.				

(IF MORE THAN FIVE, PLEASE ADD A CONTINUATION PAGE)

III. NWTS PARTICIPANT'S SOCIAL HISTORY

Has _____ experienced any significant events such as moving away from home, marriage, pregnancy or parenthood? If yes, please use the space below to report each event.

Event	Date of Occurrence	Description/Outcome

IV. NWTs PARTICIPANT'S SIBLINGS:

(Note half siblings with *, and indicate natural parent (mother/father) shared with NWTs Participant.)

Full Name or "Still Born", etc.	Sex/ Birth date	Serious Illnesses	Death: Date/Cause
1.			
2.			
3.			
4.			
5.			

(IF MORE THAN FIVE, PLEASE ADD A CONTINUATION PAGE)

V. AUTHORIZATION AND CONTACT DATA

Currently we are receiving information about NWTs Participant from her/his doctor. In the future, may we have your permission to contact you directly for this information? YES NO

If yes, by phone? YES NO

by mail? YES NO

Name: _____ Relationship to NWTs Participant : _____

Address: _____

Phone Number: (_____) _____

Please identify two individuals, (not living at your address), who should know NWTs Participant's whereabouts so if you move we can maintain contact with her/him.

Name: _____ Relationship to NWTs Participant: _____

Address: _____ Phone Number: (_____) _____

Name: _____ Relationship to NWTs Participant: _____

Address: _____ Phone Number: (_____) _____

COMMENTS:

Signature of person completing this form: _____

Relationship to NWTs Participant: _____ Date this Form Completed: _____

Please mail the completed form to:

National Wilms Tumor Study, Fred Hutchinson Cancer Research Center
1100 Fairview Avenue N, M2-A876, P.O. Box 19024, Seattle, WA 98109
Telephone: (206) 667-4842, Message Line: (800) 553-4878, Fax #: (206) 667-6623