# NWTS-5 FAMILY QUESTIONNAIRE

## A. PATIENT DATA

Patient name: ______________________________ Patient ID#: ☐☐☐☐☐☐

Social Security #: ____ ____ ____-____ ____-___ ___ ___ ___ Birth date: ________/________/________
mm dd yy

Birth weight: _____lbs________oz Birth place: ______________________________

## B. PARENT DATA

| | Natural father | Natural mother |
|---|---|---|
| 1. Name | 1.________________________ | 1.________________________ |
| 2. Birthdate | 2.________________________ | 2.________________________ |
| 3. Social Security #: | 3.________________________ | 3.________________________ |
| 4. Current address | 4.________________________ (Street)<br>________________________ (City, State, Zip Code) | 4.________________________ (Street)<br>________________________ (City, State, Zip Code) |
| 5. Phone number | 5.(          )________________ | 5.(          )________________ |
| 6. Current employer | 6.________________________ (Name and type of business)<br>________________________ (Address)<br>________________________ (Phone number with area code) | 6.________________________ (Name and type of business)<br>________________________ (Address)<br>________________________ (Phone number with area code) |
| 7. Occupation during 1-year period before child's birth | 7.________________________ (Title) (Dates)<br>________________________ (Occupation, duties, materials handled) | 7.________________________ (Title) (Dates)<br>________________________ (Occupation, duties, materials handled) |
| 8. Cancer/birth defects | 8.________________________<br>________________________ | 8.________________________<br>________________________ |
| 9. Deceased? (Cause/Date) | 9.________________________ | 9.________________________ |

## C. PATIENT AND PATIENT'S SIBLINGS

List all pregnancies including patient, still births, miscarriages, etc. Please indicate half-siblings with * and note if natural parent is the mother or the father of the patient. Please record all medical conditions (except common infections) e.g. birth defects, moles, birthmarks, tumors, or kidney ailments. Include reasons for any hospitalizations or surgery.

| | | | | ***If deceased:*** | | |
|---|---|---|---|---|---|---|
| Name or stillborn, miscarriage, etc. | Sex and birthdate | Pregnancy history | Child's illnesses | Date of death (mm/dd/yy) | Cause of death | City and state |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |



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Patient ID#: ☐☐☐☐☐☐

C. PATIENT'S SIBLINGS (continuted)

| Name or stillborn, miscarriage, etc. | Sex and birthdate | Pregnancy history | Child's illnesses | *If deceased:* Date of death (mm/dd/yy) | Cause of death | City and state |
|---|---|---|---|---|---|---|
| 7. | | | | | | |
| 8. | | | | | | |
| 9. | | | | | | |

D. EXTENDED FAMILY MEDICAL HISTORY

Do you know of any blood relatives with cancer, kidney tumors or birth defects? If so, please specify below.

Natural Mother's Side

| Name | Year born | Sex | Relation to mother | Disease | Year illness began | *If deceased* Date of death (mm/dd/yy) | Hospital | City and state |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

Natural Father's Side

| Name | Year born | Sex | Relation to father | Disease | Year illness began | *If deceased* Date of death (mm/dd/yy) | Hospital | City and State |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |



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Patient ID#: ☐☐☐☐☐☐

## F. AUTHORIZATION AND CONTACT DATA

Please provide information about your current family physician and about a relative not living at the patient's address who will most likely know how to contact you should you move.

| Relative | Physician |
|---|---|
| NAME (Last, First, Middle) | NAME (Last, First, Middle) |
| ADDRESS (Street) | ADDRESS (Street) |
| ADDRESS(City, State, Zip Code) | ADDRESS(City, State, Zip Code) |
| TELEPHONE NUMBER(Include area code) | TELEPHONE NUMBER(Include area code) |
| RELATIONSHIP TO PATIENT | |

May we have your permission to contact you if we have any questions? ( )No ( )Yes

May we have your permission to contact your physician if we have any questions? ( )No ( )Yes

Signature of person completing this form: ______________________________

Relationship to patient: ____________________ Date this form completed: ______/______/______
mm dd yy

PLEASE RETURN THE COMPLETED FORM TO:

**NATIONAL WILMS TUMOR STUDY GROUP**

**DATA AND STATISTICAL CENTER**

**FRED HUTCHINSON CANCER RESEARCH CENTER**

1100 Fairview Avenue N, P.O. Box 19024, Seattle, Washington 98109

**Questions? Please call:** Telephone: (206) 667-4842, 1-800-553-4878, Fax #: (206) 667-6623



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