NWTS LATE EFFECTS STUDY
FAMILY AND MEDICAL HISTORY FORM

Participant Name: ______________________ NWTS # (if known): __________

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. 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. ______ (Street) ______ (City, State, Zip Code)	5. ______ (Street) ______ (City, State, Zip Code)
6. Phone Number	6. ( ) ______	6. ( ) ______
7. Current Employer	7. ______ (Name and type of business) ( ) ______ (Phone Number)	7. ______ (Name and type of business) ( ) ______ (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

revised 10/09

(PLEASE COMPLETE BOTH SIDES)

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NWTS # (if known): __________

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

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

(PLEASE COMPLETE BOTH SIDES)