Fanconi Anemia Registry 01
FAR01 Malignancy history

Patient initials (first name / last name) |__|__|

Quarter and year of birth (q/yyyy) |__| / |__|__|__|__|

Sex: ☐ male ☐ female

Please enclose all reports

MDS/AML ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ HSCT ☐ other

Specify treatment |_____|

Oral cavity malignancy ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: |_____|

Malignancy of the pharynx/larynx ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: |_____|

Malignancy of the gastrointestinal tract ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: |_____|

Malignancy of the reno-urogenital tract ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: |_____|

Breast cancer ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: |_____|

Ovarian cancer ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: |_____|

Malignancy of the cervix ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the vagina ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the vulva ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the anus ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the skeletal system tract ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of brain/eyes ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the ears ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the skin ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Malignancy of the liver ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

Other malignancy ☐ no ☐ yes, Date of onset |__|__||__|__||__|__|

Resolution of condition ☐ no ☐ yes, Date of resolution |__|__||__|__||__|__|

Treatment: ☐ chemo ☐ radiation ☐ surgery ☐ other

Specify treatment: I_____I

☐Other, specify _____

Further comments: _____

Referring physician name and institution I_____I

Address I_____I

Telephone and fax I_____I

email I_____I

Date I__I__II__I__II__I__I Signature _____