

Large Granular Lymphocyte (LGL) Leukemia Registry PATIENT HISTORY

Family Medical History

Part 1 – Family Members with Autoimmune Diseases:

Do you have any family members who have been *diagnosed with an autoimmune disease* (e.g. rheumatoid arthritis, lupus, diabetes, multiple sclerosis, scleroderma, etc.)? No Yes Don't Know

- If you answered 'No' or 'Don't Know' to the above question, please skip to "Part 2 – Family Members with Cancer" on page 4.
- If you answered 'Yes' to the above question, please complete one box (below) for each family member diagnosed with an autoimmune disease.

Type of Family Member (please check):

<p><i>Immediate Family:</i></p> <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother, sister <input type="checkbox"/> son, daughter	<p><i>Other:</i> If the family member is listed to the right, which side of the family is this person on?</p> <input type="checkbox"/> mother's side <input type="checkbox"/> father's side	<input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> niece <input type="checkbox"/> nephew <input type="checkbox"/> cousin	<input type="checkbox"/> grandson <input type="checkbox"/> granddaughter <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother	<input type="checkbox"/> great grandfather <input type="checkbox"/> great grandmother <input type="checkbox"/> great granddaughter <input type="checkbox"/> great grandson <input type="checkbox"/> other: _____
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<p>Type of Autoimmune Disease:</p> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Juvenile / Type 1 Diabetes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't Know	<p>Treatment:</p> _____ _____ _____ _____ _____ _____	<p>Age at Diagnosis:</p> _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old	<p>Gender:</p> <input type="checkbox"/> Male <input type="checkbox"/> Female
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Type of Family Member (please check):

<p><i>Immediate Family:</i></p> <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother, sister <input type="checkbox"/> son, daughter	<p><i>Other:</i> If the family member is listed to the right, which side of the family is this person on?</p> <input type="checkbox"/> mother's side <input type="checkbox"/> father's side	<input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> niece <input type="checkbox"/> nephew <input type="checkbox"/> cousin	<input type="checkbox"/> grandson <input type="checkbox"/> granddaughter <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother	<input type="checkbox"/> great grandfather <input type="checkbox"/> great grandmother <input type="checkbox"/> great granddaughter <input type="checkbox"/> great grandson <input type="checkbox"/> other: _____
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<p>Type of Autoimmune Disease:</p> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Juvenile / Type 1 Diabetes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't Know	<p>Treatment:</p> _____ _____ _____ _____ _____ _____	<p>Age at Diagnosis:</p> _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old	<p>Gender:</p> <input type="checkbox"/> Male <input type="checkbox"/> Female
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Type of Family Member (please check):

<p><i>Immediate Family:</i></p> <input type="checkbox"/> mother <input type="checkbox"/> father <input type="checkbox"/> brother, sister <input type="checkbox"/> son, daughter	<p><i>Other:</i> If the family member is listed to the right, which side of the family is this person on?</p> <input type="checkbox"/> mother's side <input type="checkbox"/> father's side	<input type="checkbox"/> aunt <input type="checkbox"/> uncle <input type="checkbox"/> niece <input type="checkbox"/> nephew <input type="checkbox"/> cousin	<input type="checkbox"/> grandson <input type="checkbox"/> granddaughter <input type="checkbox"/> grandfather <input type="checkbox"/> grandmother	<input type="checkbox"/> great grandfather <input type="checkbox"/> great grandmother <input type="checkbox"/> great granddaughter <input type="checkbox"/> great grandson <input type="checkbox"/> other: _____
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<p>Type of Autoimmune Disease:</p> <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Juvenile / Type 1 Diabetes <input type="checkbox"/> Psoriasis <input type="checkbox"/> Scleroderma <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't Know	<p>Treatment:</p> _____ _____ _____ _____ _____ _____	<p>Age at Diagnosis:</p> _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old	<p>Gender:</p> <input type="checkbox"/> Male <input type="checkbox"/> Female
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Type of Family Member (please check):

Immediate Family:

- mother
- father
- brother, sister
- son, daughter

Other:

If the family member is listed to the right, which side of the family is this person on?

- mother's side
- father's side

- aunt
- uncle
- niece
- nephew
- cousin

- grandson
- granddaughter
- grandfather
- grandmother

- great grandfather
- great grandmother
- great granddaughter
- great grandson
- other: _____

Type of Autoimmune Disease:

Treatment:

Age at Diagnosis:

- Rheumatoid Arthritis _____ years old
- Lupus _____ years old
- Juvenile / Type 1 Diabetes _____ years old
- Psoriasis _____ years old
- Scleroderma _____ years old
- Multiple Sclerosis _____ years old
- Other _____ years old
- Don't Know _____ years old

Gender:

- Male Female

Type of Family Member (please check):

Immediate Family:

- mother
- father
- brother, sister
- son, daughter

Other:

If the family member is listed to the right, which side of the family is this person on?

- mother's side
- father's side

- aunt
- uncle
- niece
- nephew
- cousin

- grandson
- granddaughter
- grandfather
- grandmother

- great grandfather
- great grandmother
- great granddaughter
- great grandson
- other: _____

Type of Autoimmune Disease:

Treatment:

Age at Diagnosis:

- Rheumatoid Arthritis _____ years old
- Lupus _____ years old
- Juvenile / Type 1 Diabetes _____ years old
- Psoriasis _____ years old
- Scleroderma _____ years old
- Multiple Sclerosis _____ years old
- Other _____ years old
- Don't Know _____ years old

Gender:

- Male Female

Type of Family Member (please check):

Immediate Family:

- mother
- father
- brother, sister
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Other:

If the family member is listed to the right, which side of the family is this person on?

- mother's side
- father's side

- aunt
- uncle
- niece
- nephew
- cousin

- grandson
- granddaughter
- grandfather
- grandmother

- great grandfather
- great grandmother
- great granddaughter
- great grandson
- other: _____

Type of Autoimmune Disease:

Treatment:

Age at Diagnosis:

- Rheumatoid Arthritis _____ years old
- Lupus _____ years old
- Juvenile / Type 1 Diabetes _____ years old
- Psoriasis _____ years old
- Scleroderma _____ years old
- Multiple Sclerosis _____ years old
- Other _____ years old
- Don't Know _____ years old

Gender:

- Male Female

Part 2 – Family Members with Cancer:

Do you have any family members who have been *diagnosed with cancer*? No Yes Don't Know

- If you answered 'No' or 'Don't Know' to the above question, you are finished. Thank you for your participation.
- If you answered 'Yes' to the above question, please complete one box (below) for each family member diagnosed with cancer. (Attach copies of the sheet if more space is needed.)

Type of Family Member: (please check)

<i>Immediate Family:</i>	<i>Other:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> mother	If the family member is listed to the right, which side of the family is this person on?	<input type="checkbox"/> aunt	<input type="checkbox"/> grandson	<input type="checkbox"/> great grandfather
<input type="checkbox"/> father		<input type="checkbox"/> uncle	<input type="checkbox"/> granddaughter	<input type="checkbox"/> great grandmother
<input type="checkbox"/> brother, sister		<input type="checkbox"/> niece	<input type="checkbox"/> grandfather	<input type="checkbox"/> great granddaughter
<input type="checkbox"/> son, daughter	<input type="checkbox"/> mother's side	<input type="checkbox"/> nephew	<input type="checkbox"/> grandmother	<input type="checkbox"/> great grandson
	<input type="checkbox"/> father's side	<input type="checkbox"/> cousin		<input type="checkbox"/> other: _____

Type of Cancer:	Treatment:	Age at Diagnosis:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Chronic Myelogenous Leukemia (CML)	_____	_____ years old	
<input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL)	_____	_____ years old	
<input type="checkbox"/> Acute Lymphocytic Leukemia (ALL)	_____	_____ years old	
<input type="checkbox"/> Acute Myeloid Leukemia (AML)	_____	_____ years old	
<input type="checkbox"/> Hairy Cell Leukemia	_____	_____ years old	
<input type="checkbox"/> Non-Hodgkin's Lymphoma	_____	_____ years old	
<input type="checkbox"/> Hodgkin's Lymphoma	_____	_____ years old	
<input type="checkbox"/> Other _____	_____	_____ years old	
<input type="checkbox"/> Don't Know	_____	_____ years old	

What is this person's status? (check all that apply)

<input type="checkbox"/> Family member died - death was related to this cancer	<input type="checkbox"/> Cancer is currently being treated
<input type="checkbox"/> Family member died – death was <u>not</u> related to this cancer	<input type="checkbox"/> Cancer is in remission
<input type="checkbox"/> Cancer was treated successfully, there is no longer evidence of cancer	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Other: _____

Type of Family Member: (please check)

<i>Immediate Family:</i>	<i>Other:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> mother	If the family member is listed to the right, which side of the family is this person on?	<input type="checkbox"/> aunt	<input type="checkbox"/> grandson	<input type="checkbox"/> great grandfather
<input type="checkbox"/> father		<input type="checkbox"/> uncle	<input type="checkbox"/> granddaughter	<input type="checkbox"/> great grandmother
<input type="checkbox"/> brother, sister		<input type="checkbox"/> niece	<input type="checkbox"/> grandfather	<input type="checkbox"/> great granddaughter
<input type="checkbox"/> son, daughter	<input type="checkbox"/> mother's side	<input type="checkbox"/> nephew	<input type="checkbox"/> grandmother	<input type="checkbox"/> great grandson
	<input type="checkbox"/> father's side	<input type="checkbox"/> cousin		<input type="checkbox"/> other: _____

Type of Cancer:	Treatment:	Age at Diagnosis:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
<input type="checkbox"/> Chronic Myelogenous Leukemia (CML)	_____	_____ years old	
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<input type="checkbox"/> Acute Lymphocytic Leukemia (ALL)	_____	_____ years old	
<input type="checkbox"/> Acute Myeloid Leukemia (AML)	_____	_____ years old	
<input type="checkbox"/> Hairy Cell Leukemia	_____	_____ years old	
<input type="checkbox"/> Non-Hodgkin's Lymphoma	_____	_____ years old	
<input type="checkbox"/> Hodgkin's Lymphoma	_____	_____ years old	
<input type="checkbox"/> Other _____	_____	_____ years old	
<input type="checkbox"/> Don't Know	_____	_____ years old	

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Type of Family Member: (please check)

<i>Immediate Family:</i>	<i>Other:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/> father		<input type="checkbox"/> uncle	<input type="checkbox"/> granddaughter	<input type="checkbox"/> great grandmother
<input type="checkbox"/> brother, sister		<input type="checkbox"/> niece	<input type="checkbox"/> grandfather	<input type="checkbox"/> great granddaughter
<input type="checkbox"/> son, daughter	<input type="checkbox"/> mother's side	<input type="checkbox"/> nephew	<input type="checkbox"/> grandmother	<input type="checkbox"/> great grandson
	<input type="checkbox"/> father's side	<input type="checkbox"/> cousin		<input type="checkbox"/> other: _____

Type of Cancer: <input type="checkbox"/> Chronic Myelogenous Leukemia (CML) <input type="checkbox"/> Chronic Lymphocytic Leukemia (CLL) <input type="checkbox"/> Acute Lymphocytic Leukemia (ALL) <input type="checkbox"/> Acute Myeloid Leukemia (AML) <input type="checkbox"/> Hairy Cell Leukemia <input type="checkbox"/> Non-Hodgkin's Lymphoma <input type="checkbox"/> Hodgkin's Lymphoma <input type="checkbox"/> Other _____ <input type="checkbox"/> Don't Know	Treatment: _____ _____ _____ _____ _____ _____ _____ _____	Age at Diagnosis: _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old _____ years old	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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<input type="checkbox"/> son, daughter		<input type="checkbox"/> nephew	<input type="checkbox"/> grandmother	<input type="checkbox"/> great grandson
	<input type="checkbox"/> mother's side	<input type="checkbox"/> cousin		<input type="checkbox"/> other: _____
	<input type="checkbox"/> father's side			

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<input type="checkbox"/> father		<input type="checkbox"/> uncle	<input type="checkbox"/> granddaughter	<input type="checkbox"/> great grandmother
<input type="checkbox"/> brother, sister		<input type="checkbox"/> niece	<input type="checkbox"/> grandfather	<input type="checkbox"/> great granddaughter
<input type="checkbox"/> son, daughter		<input type="checkbox"/> nephew	<input type="checkbox"/> grandmother	<input type="checkbox"/> great grandson
	<input type="checkbox"/> mother's side	<input type="checkbox"/> cousin		<input type="checkbox"/> other: _____
	<input type="checkbox"/> father's side			

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<input type="checkbox"/> Cancer was treated successfully, there is no longer evidence of cancer	<input type="checkbox"/> Don't know
	<input type="checkbox"/> Other: _____