

Family History of Cancer Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____
 Provider: _____

Date of Birth: _____
 Date Completed: _____

Please circle **Y** to those that apply to **YOU and/or YOUR FAMILY** (on both **MOTHER** and **FATHER'S** side.)
 Please list your relationship to the individual diagnosed and the age at cancer diagnosis.

Please consider the following family members: PARENTS, SIBLINGS, GRANDPARENTS, AUNTS, UNCLER, NIECES, & NEPHEWS

<u>BREAST and OVARIAN CANCER</u>		<u>Relationship (Ex. Maternal Aunt)</u>	<u>Age at Diagnosis</u>
Breast cancer Before age 50	Y / N	_____	_____
Ovarian cancer at any age	Y / N	_____	_____
Breast cancer in both breasts or multiple primary breast cancers at any age	Y / N	_____	_____
Male breast cancer at any age	Y / N	_____	_____
Three or more breast cancers on the same side of the family at any age	Y / N	_____	_____
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y / N	_____	_____
Pancreatic cancer AND two breast cancers on the same side of the family	Y / N	_____	_____
 <u>Colon & Uterine Cancer</u>			
Endometrial (uterine) cancer before age 50	Y / N	_____	_____
Colorectal cancer before age 50	Y / N	_____	_____
Three or more of any of the following cancers (individual or Family) at any age: uterine, colorectal, ovarian, stomach, kidney/urinary, or small bowel	Y / N	_____	_____
		_____	_____
		_____	_____

If you circled yes to one or more statements on the Family History Questionnaire, you may be appropriate for a blood or saliva test to help determine if you have an inherited risk of cancer. Please ask your provider

FOR OFFICE USE ONLY

Did patient meet criteria for Genetic Testing?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> More information needed
If YES, Patient chose to:	<input type="radio"/> Accepted	<input type="radio"/> Declined	
Patient Signature for declined testing: _____		Date: _____	
Provider Signature: _____		Date: _____	