

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Gender (M/F): _____ Today's Date(MM/DD/YY): _____ Health Care Provider: _____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
 If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately; parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
Have you or your family members been diagnosed with any of the following:		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer <input checked="" type="radio"/> Y <input type="radio"/> N		Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 45 <input type="radio"/> Y <input type="radio"/> N					
2 or more separate breast cancers in one person, one at age 50 or younger <input type="radio"/> Y <input type="radio"/> N					
2 or more people on the same side of my family (can include me) with breast cancer, one at age 50 or younger <input type="radio"/> Y <input type="radio"/> N					
Ovarian (peritoneal/fallopian tube) cancer at any age <input type="radio"/> Y <input type="radio"/> N					
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology) <input type="radio"/> Y <input type="radio"/> N					
3 or more of these cancers on same side of my family at any age: pancreatic, breast, or aggressive prostate* <input type="radio"/> Y <input type="radio"/> N					
<small>*Gleason Score ≥7</small>					
Male breast cancer at any age <input type="radio"/> Y <input type="radio"/> N					
Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age <input type="radio"/> Y <input type="radio"/> N					
Pancreatic cancer or aggressive prostate cancer and one relative with breast cancer at age 50 or younger <input type="radio"/> Y <input type="radio"/> N					
20 or more colon/rectal polyps found in 1 person throughout their lifetime. Specify number _____ <input type="radio"/> Y <input type="radio"/> N					
Colon/rectal or Endometrial (uterine) cancer before age 50 <input type="radio"/> Y <input type="radio"/> N					
Personal history of Endometrial (uterine) cancer at any age ‡ <input type="radio"/> Y <input type="radio"/> N					
TWO individuals on the same side of my family (can include me): at least 1 with colon/rectal or endometrial (uterine) cancer at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer <input type="radio"/> Y <input type="radio"/> N					
THREE OR MORE individuals on the same side of my family (can include me) with a Lynch-associated* cancer at any age, with at least 1 being a colon/rectal or endometrial (uterine) cancer <input type="radio"/> Y <input type="radio"/> N					

‡ PREMM1,2,3 Score > 5%

* Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

Have you or a family member had genetic testing for a hereditary cancer syndrome? Y N

If yes, Who? _____ What gene(s)? _____
 What was the result? _____

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only

Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

If YES, which test? BRACAnalysis* with Myriad myRisk* Multisite 3 BRACAnalysis REFLX to BRACAnalysis with Myriad myRisk

COLARIS* PLUS with Myriad myRisk COLARIS AP* PLUS with Myriad myRisk Single Site Testing Myriad myRisk Update Other _____

Follow-up appointment scheduled YES NO Date of Next Appointment: _____