Family History of Cancer Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________________ Date of Birth: ___________________

Provider: __________________________________ Date Completed: ________________

Please circle **Y** to those that apply to **YOU and/or YOUR FAMIL Y** (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, UNCLES, NIECES, & NEPHEWS

BREAST and OVARIAN CANCER		Relationship (Ex. Maternal Aunt)	Age at Diagnosis
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	____________	____________
Colon & Uterine Cancer			
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

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Did patient meet criteria for Genetic Testing? O Yes O No O More information needed
If YES, Patient chose to: O Accepted O Declined
Patient Signature for declined testing: ______________________ Date: ____________
Provider Signature: ______________________________ Date: ____________