Personal & Family History Questionnaire for Hereditary Cancer Risk Assessment

Patient Name:________________________________ Physician:____________________________

Date of Birth:________________________________ Today's Date:_________________________

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

Please circle "Yes" or "No" below if there is a personal or family history of any of the following cancers.

Include both sides of your family and list each member separately:

Self, Parents, Children, Brothers, Sisters, Grandparents, Aunts, Uncles, Nieces, Nephews, Cousins

Personal & Family History Have you or your family members been diagnosed with any of the following:			**You** Age at Diagnosis	**Siblings/Children** Family Member & Age at Dx	**Mother's Side** Family Member & Age at Dx	**Father's Side** Family Member & Age at Dx
Example: Breast Cancer	(Y)	N	49	Sister-55 Daughter-33	Aunt #1-67 Aunt #2-45	Grandma-84
Breast cancer at age 50 or younger	Y	N				
Ovarian cancer at any age	Y	N				
Male **breast cancer** at any age	Y	N				
3 or more family members with **breast cancer** at any age	Y	N				
3 or more family members with **pancreatic OR breast cancer** at any age:	Y	N				
Breast cancer in both breasts or multiple primary breast cancers in the same person at any age	Y	N				
Ashkenazi Jewish ancestry with a personal or family history of **breast, or pancreatic cancer** at any age	Y	N				
Have you had **uterine cancer** at any age?	Y	N				
Uterine cancer before age 50	Y	N				
Colorectal cancer before age 50	Y	N				
Any 3 of the following cancers diagnosed at any age: ***(Colon, Uterine, Ovarian, Stomach, Brain, Pancreatic, Kidney)***	Y	N				
Have you or a family member had **genetic testing** for a BRCA or Lynch mutation?	Y	N	If yes, who in your family had testing & when?			

Patient Signature:________________________________ Date:______________________________

For Office Use Only:

Did patient meet criteria for Genetic Testing? ❑YES ❑NO

If YES, did patient accept same day testing? ❑YES ❑NO

Provider Signature:______________________________________ **Date:**________________