Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ Physician: ______________________

Date of Birth: ______________________ Date Completed: ______________________

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
For example: Colorectal cancer	none	–	Brother	36 yrs	Aunt Cousin	44 yrs 58 yrs	Grandfather	65 yrs
BREAST AND OVARIAN CANCER								
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								
Pancreatic cancer								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

	YOU	Age at Diagnosis	SIBLINGS/ CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
COLON AND UTERINE CANCER								
Uterine (endometrial) cancer								
Colorectal cancer								
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer								
10 or more cumulative colon polyps								
MELANOMA								
Melanoma								
Pancreatic cancer								
OTHER CANCER								
______________________								

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER HAD GENETIC TESTING FOR HEREDITARY RISK OF CANCER?

☐ Yes ☐ No If yes, please explain: ______________________

If answered "yes", obtain copy of relatives test result.

FOR OFFICE USE ONLY	
☐ Patient appropriate for further risk assessment and/or genetic testing ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer syndrome ☐ COLARIS® – A test for Lynch syndrome (Hereditary Nonpolyposis Colorectal Cancer) ☐ COLARIS *AP*® – A test for Adenomatous Polyposis syndromes ☐ MELARIS® – A test for Hereditary Melanoma	☐ Discussed hereditary cancer risk with patient ☐ Patient offered genetic testing ☐ ACCEPTED ☐ DECLINED ☐ Follow up appointment scheduled Date: ____________

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.myriadtests.com

Myriad, the Myriad logo, BRAC*Analysis*, COLARIS, COLARIS *AP*, and MELARIS are either trademarks or registered trademarks of Myriad Genetics, Inc., in the United States and other jurisdictions. ©2010, Myriad Genetic Laboratories, Inc.

MYRIAD®

SELF		NON-HEREDITARY BREAST CANCER
Y	N	Have you ever been diagnosed with any breast cancer, or ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS)?
Y	N	Are you Caucasian?
Y	N	Are you 35 years old or older?
Y	N	Have you been tested for BRCA1/BRCA2? If so, was the test result negative? Y / N (circle one)
Y	N	Did you start your menstrual period before age 12?
Y	N	Did you start menopause after the age of 50?
Y	N	Did you have your first child AFTER 30 years of age?
Y	N	Are you nulliparous? (i.e. never given birth)?
Y	N	Have you ever been told you have dense breasts?
Y	N	Have you ever had a (positive or negative) biopsy?
Y	N	Have any of your 1st degree relatives (mother, sister, daughter) ever been diagnosed with breast cancer?
Y	N	Have you ever taken estrogen for Hormone Replacement Therapy (HRT)?

Patient's signature ______________________ Date __________

FOR OFFICE USE ONLY

Patient is - is not appropriate for further risk assessment and - or genetic testing.

Patient offered sporadic breast cancer risk assessment testing (BREVAGen) Accepted OR Declined

Follow-up appointment scheduled on ______________________

Information for patient's review provided on ______________________

HCP Signature

Phenogen Sciences Inc. 9115 Harris Corners Parkway, Suite 320, Charlotte NC 28269
Toll free 877-99-BREVA (27382) **Facsimile** 704-926-5707 **Email** info@phenogensciences.com **wesbite** www.phenogensciences.com

BVRA001.V1 OCT 2012