

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____ Date of Birth: _____

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

	YOU	Age at Diagnosis	SIBLINGS/CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
Breast cancer								
Ovarian cancer								
Breast cancer in both breasts OR multiple primary breast cancers								
Male breast cancer								

Are you of Ashkenazi Jewish descent? Yes No

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

	YOU	Age at Diagnosis	SIBLINGS/CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
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

	YOU	Age at Diagnosis	SIBLINGS/CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis
Melanoma								
Pancreatic cancer								

OTHER CANCER

	YOU	Age at Diagnosis	SIBLINGS/CHILDREN	Age at Diagnosis	MOTHER'S SIDE	Age at Diagnosis	FATHER'S SIDE	Age at Diagnosis

HAVE YOU OR ANY MEMBER OF YOUR FAMILY EVER BEEN TESTED FOR HEREDITARY RISK OF CANCER?

Yes No If yes, please explain: _____

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<input type="checkbox"/> Patient appropriate for further risk assessment and/or genetic testing <input type="checkbox"/> BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer Syndrome <input type="checkbox"/> COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® – A test for Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma	<input type="checkbox"/> Discussed hereditary cancer risk with patient <input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED <input type="checkbox"/> Follow up appointment scheduled Date: _____