

# Personal and Family History Questionnaire for Hereditary Cancer Risk Assessment

TODAY'S DATE:	PATIENT NAME:	DATE OF BIRTH:	AGE:
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## 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 and nephews

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
<b>EXAMPLE:</b> 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
<b>Breast cancer</b> at or before age 45	<input type="radio"/> Y <input type="radio"/> N				
2 or more separate <b>breast cancers</b> in one person, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
2 relatives with <b>breast cancer</b> , one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
<b>Ovarian cancer</b> at any age	<input type="radio"/> Y <input type="radio"/> N				
<b>Triple Negative Breast cancer</b> at age 60 or younger	<input type="radio"/> Y <input type="radio"/> N				
3 or more of these cancers on same side of the family at any age: <b>pancreatic, breast, or aggressive prostate</b>	<input type="radio"/> Y <input type="radio"/> N				
Male <b>breast cancer</b> at any age	<input type="radio"/> Y <input type="radio"/> N				
Jewish ancestry with <b>breast cancer</b> at any age	<input type="radio"/> Y <input type="radio"/> N				
Jewish ancestry with <b>pancreatic cancer</b> and one relative with <b>breast, ovarian, pancreatic OR aggressive prostate cancer</b>	<input type="radio"/> Y <input type="radio"/> N				
10 or more <b>pre-cancerous colon polyps</b> found in 1 person throughout their lifetime. Total number _____	<input type="radio"/> Y <input type="radio"/> N				
<b>Colorectal or Uterine (endometrial) cancer</b> before age 50	<input type="radio"/> Y <input type="radio"/> N				
<u>TWO</u> individuals in my family (myself included): at least 1 with <b>colorectal or uterine (endometrial) cancer</b> at any age <u>AND ALSO</u> 1 diagnosed before age 50 with a Lynch-associated* cancer	<input type="radio"/> Y <input type="radio"/> N				
<u>THREE OR MORE</u> individuals in my family (myself included) with a <b>Lynch-associated* cancer</b> at any age, with at least 1 being a colorectal or uterine (endometrial) cancer	<input type="radio"/> Y <input type="radio"/> N				

\* Lynch-associated cancers include: colon, uterine (endometrial), 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 <b>BRCA, Lynch or polyposis mutation</b> ?	<input type="radio"/> Y <input type="radio"/> N	If yes, who in your family had testing, when, and if known, where?:
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OFFICE USE ONLY	<ul style="list-style-type: none"> <li>Does patient meet: 1. NCCN guidelines for HBOC? <input type="radio"/> Y <input type="radio"/> N    2. NCCN guidelines for (A)FAP? <input type="radio"/> Y <input type="radio"/> N</li> <li>3. SGO guidelines for Lynch syndrome? <input type="radio"/> Y <input type="radio"/> N</li> <li>Genetic testing recommended? <input type="radio"/> Y <input type="radio"/> N</li> <li>If YES, which test? <input type="radio"/> BRCA<sup>Analysis</sup>® with Myriad myRisk™    <input type="radio"/> COLARIS® with Myriad myRisk™</li> <li><input type="radio"/> COLARISAP® with Myriad myRisk™    <input type="radio"/> Multi-Site with Reflex Myriad myRisk™    <input type="radio"/> Single Site _____</li> <li>Provide rationale for recommendation: <input type="radio"/> Guidelines met    <input type="radio"/> Other (please specify): _____</li> <li>Patient accepts same day genetic testing: <input type="radio"/> Y <input type="radio"/> N</li> <li>Patient advised to schedule follow-up appointment: <input type="radio"/> Y <input type="radio"/> N</li> </ul>	
	PROVIDER'S SIGNATURE:	TODAY'S DATE: