

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	<i>none</i>	<i>—</i>	<i>Brother</i>	<i>36 yrs</i>	<i>Aunt Cousin</i>	<i>44 yrs 58 yrs</i>	<i>Grandfather</i>	<i>65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer (male or female)

Ovarian cancer

Breast cancer in both breasts OR
multiple primary breast cancers

Male breast cancer

Pancreatic or prostate cancer

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

COLON AND UTERINE CANCER

Uterine (endometrial) cancer

Colorectal cancer

Colon/rectal, uterine/endometrial,
ovarian, stomach/gastric,
kidney/urinary tract, biliary tract,
small bowel, pancreas, brain, and
sebaceous adenomas

10 or more cumulative colon polyps

MELANOMA

Melanoma

Pancreatic cancer

OTHER CANCER

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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

<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: _____
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