Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth _____ Date: _____

Instructions: Please circle **Y** to those that apply to **YOU and YOUR FAMILY** (Both mother's and Father's Side). Behind each statement, please list the relationship **TO YOU** of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) **and their age at diagnosis**. If you circle **Y** to any statements below, you **MAY** be appropriate for genetic testing. Your healthcare provider will have additional information for you.

		Relationship	**Age at Diagnosis**
Y N	Breast Cancer before age 50	_____	_____
Y N	Ovarian Cancer	_____	_____
Y N	Breast Cancer in both breasts or multiple breast cancers	_____ _____	_____ _____
Y N	Both breast and Ovarian Cancer (in an individual or a family)	_____ _____	_____ _____
Y N	Male Breast Cancer	_____	_____
Y N	2 or more Breast or Ovarian Cancers (in an individual or a family)	_____ _____	_____ _____
Y N	Ashkenazi Jewish ancestry and personal Family history of breast or ovarian Cancer	_____ _____	_____ _____

COLON AND UTERINE CANCER

Y N	Uterine Cancer before age 50	_____	_____
Y N	Colorectal Cancer before age 50	_____	_____
Y N	Both Uterine and Colorectal Cancer (in an individual or a family)	_____ _____	_____ _____
Y N	2 or more Uterine or Colorectal Cancers (in an individual or a family)	_____ _____	_____ _____
Y N	Uterine and/or Colorectal Cancer AND Ovarian Stomach, kidney/urinary tract, brain OR small Bowel cancer (in an individual or family)	_____ _____ _____	_____ _____ _____
Y N	10 or more Colon Polyps found in a lifetime.	_____	_____

Candidate for further risk assessment and/or genetic testing
Information given to patient to review
Follow-up Appointment Date:_____

Patient offered genetic testing
Accepted **Rejected**

_____ _____
Patient Signature Date Healthcare Provider's Signature