

Family History Questionnaire for Common Hereditary Cancer Syndromes

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

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's or 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. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

	<u>RELATIONSHIP</u>	<u>AGE AT DIAGNOSIS</u>
<u>BREAST AND OVARIAN CANCER</u>		
Y N - Breast cancer before age 50	_____	_____
Y N - Ovarian cancer	_____	_____
Y N - Breast cancer after age 50	_____	_____
Y N - Both breast & ovarian cancer (in an individual or 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 & personal or family history of breast or ovarian cancer	_____ _____	_____ _____

<u>COLON AND UTERINE CANCER</u>		
Y N - Uterine cancer before age 50	_____	_____
Y N - Colorectal cancer before age 50	_____	_____
Y N - Both uterine & colorectal cancer (in an individual or 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	_____	_____

<input type="checkbox"/> Candidate for further risk assessment and/or genetic testing	<input type="checkbox"/> Patient offered genetic testing
<input type="checkbox"/> Information given to patient to review	<input type="checkbox"/> Accepted <input type="checkbox"/> Declined
<input type="checkbox"/> Follow up appointment scheduled Date: _____	Not indicated at this time

Patient's Signature

Date

Health Care Provider's Signature

Date