The Women's Center of Southern New England
A member of Women's Health Connecticut

MR#: ☐☐☐☐☐☐☐
Name of Patient:
Date of Birth:
Place Label Here

HEREDITARY CANCER RISK ASSESSMENT QUESTIONAIRE

Your Personal & Family History is Important for Us to Understand How to Best Care for You Today and In the Future.
The majority of cancers are not inherited, however, approximately 5-10% of cancers can be inherited or "run in families". This is a screening tool to help identify patient's possible risk for hereditary cancer. Be sure to include **yourself & family members on your mother & father's sides. Family members to include are parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half- Siblings and first cousins.**

Have YOU / ANYONE in your family been tested for a Hereditary Cancer Syndrome?
If Yes, Who/When:_____

Have YOU / ANYONE in your family had a positive documented hereditary cancer mutation?
If Yes, Name of Gene (BRCA1, APC, Lynch, etc)_____

Place a X in the box if you can answer Yes to any of the below questions

	SELF	FAMILY
Jewish ancestry **WITH** breast, ovarian or pancreatic cancer at ANY AGE	☐	☐
Breast cancer BEFORE age 45	☐	☐
Breast cancer in both breasts before age 50	☐	☐
Male breast cancer at ANY AGE		☐
Ovarian cancer at ANY AGE	☐	☐
Colon AND/ OR Uterine Cancer BEFORE age 50 OR family history of colon and/or uterine cancer in 3 or more individuals (same side of family)	☐	☐
Endometrial cancer BEFORE age 50	☐	☐
SAME PERSON diagnosed with Colon cancer AND a secondary diagnosis of colon, endometrium, ovary, pancreas, gastric, small intestine, renal pelvis, ureter, and /or glioblastoma?	☐	☐
3 or more relatives(including yourself) on the SAME SIDE of the family with diagnosed cancer of the following: • Breast • Pancreatic • Ovarian • Aggressive Prostate	☐	☐
3 or more relatives(including yourself) on the SAME SIDE of the family with diagnosed cancer of the following: • Colon/ Rectal • Pancreatic • Uterine/Endometrial • Small Bowel • Ovarian • Stomach • Kidney/Renal • Urinary Tract • Bladder • Brain	☐	☐
10 or more pre-cancerous polyps found in 1 person throughout their lifetime.	☐	
NONE OF THE ABOVE		☐

Patient Signature:_____ **Date:**_____

For Office Use Only: ***No Intervention necessary for patients under 25
Patient offered Genetic Counseling? ☐ Y ☐ N ☐ N/A Patient agreed to referral to Genetic Counselor? ☐ Accepted ☐ Declined

Provider Signature: _____ Date:_____

For Genetics Office Only
Patient accepts appt?, Date of appt?_____ Patient declines appt/ testing Date declined_____