Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date completed: _____

Instructions: Circle "Y" to below statements that apply to YOU and/or YOUR FAMILY on both your **mother's and father's sides**; list the diagnosed person's relationship to you (eg; self, paternal aunt, maternal uncle, paternal grandmother) and the age at diagnosis. Each statement should be answered individually, so you may list the same cancer more than once. This is a screening tool for the common features of hereditary cancer syndromes so if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

BREAST AND OVARIAN CANCER	RELATIONSHIP	AGE AT DIAGNOSIS
Y N - Breast cancer before age 50		
Y N - Ovarian cancer		
Y N - 2 primary, unrelated breast cancer in same person or same side of the family		
Y N - Both breast & ovarian cancer (in an individual or family)		
Y N - Male breast cancer		
Y N - Pancreatic cancer with breast or ovarian cancer in same person or same side of the family		
Y N - Ashkenazi Jewish ancestry with breast, ovarian or pancreatic in same person or same side of the family		

COLON AND UTERINE CANCER		
Y N - Uterine (endometrial) cancer before age 50		
Y N - Colorectal cancer before age 50		
Y N - Both uterine & colorectal cancer in same person or same side of the family		
Y N - 2 or more uterine or colorectal cancers in same person or same side of the family		
Y N - Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in same person or same side of the family		

COLON POLYP HISTORY		
Y N - 10 or more colon polyps found in a lifetime		

I acknowledge that I ☐ was counseled on / ☐ received information on / ☐ received recommendation for hereditary cancer syndrome testing. I understand and accept that it is my responsibility to review and consider information, to make an informed decision about hereditary cancer syndrome testing, and to inform this physician of my decision. At this time, I will:

☐ undergo tested ☐ make another appointment and review info before deciding ☐ decline testing

_____ _____ _____ _____

Patient's Signature Date Health Care Provider's Signature Date

☐ Candidate for further risk assessment or genetic testing ☐ Genetic testing offered ☐ F/U appt scheduled

☐ Referred to genetic counselor_____ ☐ Pt given info to review ☐ Accepted ☐ Declined

Approved 6/08; Revised 2/11; 8/11