

# Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_

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	SIBLINGS/ Aunts, Uncles, Cousins	MOTHER'S SIDE	FATHER'S SIDE
<i>For example:</i> <b>Colorectal cancer</b>		Brother 36 yrs	Aunt 44 yrs Cousin 58 yrs	Grandfather 65 yrs

## BREAST AND OVARIAN CANCER

Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breasts				
Male breast cancer				
Are you of Ashkenazi Jewish descent?				

## COLON AND UTERINE CANCER

Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more colon polyps				

## MELANOMA

Melanoma				
Pancreatic cancer				

## OTHER CANCER

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FOR OFFICE USE ONLY	
<input type="checkbox"/> Patient appropriate further risk assessment and/or genetic testing <input type="checkbox"/> BRACAnalysis® - A test for Hereditary Breast and Ovarian Cancer <input type="checkbox"/> COLARIS® - A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer) <input type="checkbox"/> COLARIS AP® - A test for Hereditary Breast and Ovarian Cancer <input type="checkbox"/> MELARIS® - A test for Hereditary Breast and Ovarian Cancer	<input type="checkbox"/> Patient given information to review <input type="checkbox"/> Patient offered genetic testing <div style="text-align: center;"> <input type="checkbox"/> ACCEPTED     <input type="checkbox"/> DECLINED         </div> <input type="checkbox"/> Follow up appointment scheduled Date: _____