Cancer Family History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

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, nieces, nephews and cousins.***

		COLON AND Uterine/Endometrial CANCER *(Colaris^{Plus})*	**Self** *Age @ Diagnosis*	**Siblings/Children** *Age @ Diagnosis*	**Mother's Side** *Age @ Diagnosis*	**Father's Side** *Age @ Diagnosis*
Y	*N*	***Colon Cancer***				
Y	*N*	***Endometrial/Uterine Cancer***				
Y	*N*	***10 or more colorectal polyps***				
Y	*N*	***Ovarian Cancer***				
Y	*N*	***Stomach/Gastric, Brain, Kidney, urinary tract, small bowel***				
		BREAST AND OVARIAN CANCER *(BRACAnalysis)*	**Self** *Age @ Diagnosis*	**Siblings/Children** *Age @ Diagnosis*	**Mother's Side** *Age @ Diagnosis*	**Father's Side** *Age @ Diagnosis*
Y	*N*	***Breast Cancer***				
Y	*N*	2 cases of Breast Cancer ***at least 1 before 50*** *(in same person or on same side of the family)*				
Y	*N*	Breast Cancer in both breasts OR multiple primary breast cancers ***at any age***				
Y	*N*	***Ovarian*** Cancer ***at any age***				
Y	*N*	Male Breast Cancer ***at any age***				
Y	*N*	Are you of Ashkenazi Jewish descent?				
Y	*N*	Breast Cancer diagnosis with Triple Negative Receptors: *(ER-, PR-, and HER2-)*				
Y	*N*	Prostate Cancer				
Y	*N*	Pancreatic Cancer				
Y	*N*	A family member with a known mutation				

Height: _____ **Weight:** _____ **Age of First Period:** _____

Age when you had First Child (if applicable**):** _____ Age at Menopause (if applicable**):** _____

Have you ever used Hormone Replacement Therapy (circle)? Yes No IF YES, for how many years**?** _____

Has anyone in your family had genetic testing for a hereditary cancer syndrome (circle)? Yes No

Are there any other cancers in you or your family that are not listed above? _____

Patients Signature: _____ *Date:* _____

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Testing? ☐ *YES* ☐ *NO*

IF YES and patient offered testing, did patient: ☐ *ACCEPT* ☐ *DECLINE*

Patient Signature for declined testing: _____ ***Date:*** _____

Follow up appointment scheduled: ☐ *YES* ☐ *NO*

Provider's Signature: _____ ***Date:*** _____