

# 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/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
<i>For example:</i> Colorectal cancer		<i>Brother 36 yrs</i>	<i>Aunt 44 yrs Cousin 58 yrs</i>	<i>Grandfather 65 yrs</i>

## BREAST AND OVARIAN CANCER

Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
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 cumulative colon polyps				

## MELANOMA

Melanoma				
Pancreatic cancer				

## OTHER CANCER

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FOR OFFICE USE ONLY	
<input type="checkbox"/> Patient appropriate for 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 Adenomatous Polyposis Syndromes <input type="checkbox"/> MELARIS® – A test for Hereditary Melanoma	<input type="checkbox"/> Discussed hereditary cancer risk with patient <input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED <input type="checkbox"/> Follow up appointment scheduled Date: _____