FAMILY HISTORY QUESTIONNAIRE FOR COMMON HEREDITARY CANCER SYNDROMES

*Patient Name:*_____

*Date of Birth*_____ *Date*_____

This is a screening tool for the common features of hereditary cancer syndromes

*Please circle **Y** to those that apply to You and/or Your Family (on both mother's and father's side) or **N** for no. Please list the relationship to you of the individual diagnosed (example: self, paternal aunt, maternal aunt, paternal grandmother) and their age when diagnosed. Should you have several individuals with same diagnosis, please list all in the relationship area. Thank You*

		RELATIONSHIP	***AGE AT DIAGNOSIS***
BREAST OR OVARIAN CANCER			
Y N	Breast Cancer	_____	_____
Y N	Breast cancer in both breasts	_____	_____
Y N	Ovarian Cancer	_____	_____
Y N	Male breast cancer	_____	_ _____
Y N	Ashkenazi Jewish ancestry	//////////////////////////////////////	//////////////////////////
Y N	Family member with BRCA mutation	_____	___ _____

ADDITIONAL COMMENTS:_____

COLON AND UTERINE CANCER			
Y N	Uterine (endometrial) cancer	_____	_____
Y N	Colorectal cancer	_____	_____
Y N	Ovarian, stomach, kidney/ urinary, brain or small bowel cancer	_____	_____
Y N	10 or more colon polyps found in a lifetime.	_____	_____
Y N	Family member with identified mutation	_____	_____
MELANOMA			
Y N	Melanoma	_____	_____
Y N	Pancreatic cancer	_____	_____

ADDITIONAL COMMENTS:_____

Physician Use Only: ☐ Pt is **NOT** a candidate for genetic testing

☐ Pt **IS** a candidate for further risk assessment and/or genetic testing ☐ Patient offered genetic testing

☐ Information given to patient to review ☐ **Considering** ☐ **Accepted** ☐ **Declined**

_____ _____

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