Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name **:** _____ Physician: _____
Date of Birth: _____ Date completed:_____

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

			RELATIONSHIP	**AGE AT DIAGNOSIS**
BREAST AND OVARIAN CANCER				
Y	N	- Breast cancer before age 50	_____	_____
Y	N	- Ovarian cancer	_____	_____
Y	N	- Breast cancer in both breasts or multiple	_____	_____
		primary breast cancers	_____	_____
Y	N	- Both breast & ovarian cancer	_____	_____
		(in an individual or family)	_____	_____
Y	N	- Male breast cancer	_____	_____
Y	N	- 2 or more breast or ovarian cancers	_____	_____
		(in an individual or a family)	_____	_____
Y	N	- Ashkenazi Jewish ancestry & personal or	_____	_____
		family history of breast or ovarian cancer	_____	_____
COLON AND UTERINE CANCER				
Y	N	- Uterine cancer before age 50	_____	_____
Y	N	- Colorectal cancer before age 50	_____	_____
Y	N	- Both uterine & colorectal cancer	_____	_____
		(in an individual or family)	_____	_____
Y	N	- 2 or more uterine or colorectal cancers	_____	_____
		(in an individual or a family)	_____	_____
Y	N	- Uterine and/or colorectal cancer AND ovarian,	_____	_____
		stomach, kidney/urinary tract, brain OR small	_____	_____
		bowel cancer (in an individual or family)	_____	_____
Y	N	- 10 or more colon polyps found in a lifetime	_____	_____

Candidate for further risk assessment and/or genetic testing	Patient offered genetic testing
Information given to patient to review	**Accepted** **Declined**
Follow up appointment scheduled Date: _____	

_____ _____

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