Risk Profile Questionnaire

Instructions: Your personal and family history is important to provide you with the best care possible. Your provider will use this information as a screening tool for cancers as well as inherited conditions that could affect you and your family. Please complete the chart below based upon your personal and family history. Leave blank what you do not know.

The following blood relatives should be considered: Parents, siblings, children, grandparents, grandchildren, aunts, uncles, nieces, and nephews, on both sides of the family.

Personal Information

Patient Name		Date of Birth	Provider Seeing Today	Today's Date	
Do you plan to become pregnant in the next year?	☐ Y ☐ N		Do you have Ashkenazi Jewish ancestry?	☐ Y ☐ N	

Have you had hereditary cancer genetic testing? ☐ Y ☐ N
If **YES**: Year tested? ________ Results: ☐ Negative ☐ Positive – for which gene? _________
If you have already had the MyRisk hereditary cancer test completed, you do not need to fill out the questions below

Do you have a PERSONAL history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, **ovarian**, or **pancreatic cancer** at any age	☐ Y ☐ N		
Colorectal or **uterine cancer** at 64 or younger	☐ Y ☐ N		

Do you have a FAMILY history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Breast cancer in both breasts (bilateral) at any age	☐ Y ☐ N		☐ M ☐ P	
Three **breast cancers** in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	☐ Y ☐ N		☐ M ☐ P	
Has anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?
Has anyone in your family been diagnosed with a genetic disease or identified as a carrier for a genetic disease?	☐ Y ☐ N	List them here:		

Patient Signature ____ Date ______________

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Patient offered carrier screening? ☐ Yes ☐ No ☐ Accepted ☐ Declined
Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

☐ Information provided ☐ Patient will confirm history with family members Provider Initials: __________________