Lakeshore Women's Specialists
Hereditary Cancer Risk Assessment Form

Patient Name:_____ Date of Birth:_____ Your OB/GYN :_____ Date of Visit:_____

Have you previously undergone cancer genetic testing such as BRCA or My Risk testing? Yes ☐ No ☐
If you answered YES, please DO NOT continue filling out the form below.

INSTRUCTIONS: **Please circle YES** to any statement below if it applies to **YOU or YOUR FAMILY MEMBERS**.
Next to each statement, please list the **AGE** of the person when they were **DIAGNOSED** with cancer and your relation.

Please include all family members on both your MOTHER'S and FATHER'S sides:

	BREAST AND OVARIAN CANCER	You or Siblings	AGE	Mother's Side	AGE	Father's Side	AGE
Y / N	Did YOU have breast cancer BEFORE age 50						
Y / N	Did your Mother, Sister, Aunt, or Grandmother have breast cancer at age 45 or younger						
Y / N	Ovarian Cancer in the family at ANY age						
Y / N	TWO or more breast cancers on the same side of the family, 1 UNDER age 50						
Y / N	THREE or more breast cancers on the same side of the family, at ANY age						
Y / N	Male Breast Cancer in the family at ANY age						
Y / N	Triple negative breast cancer in the family at age 60 or younger						
Y / N	Ashkenazi Jewish ancestry with ANY breast cancer in the family.						
Y / N	BRCA Mutation in the family						
	COLON AND UTERINE CANCER	**You or Siblings**	**AGE**	**Mother's Side**	**AGE**	**Father's Side**	**AGE**
Y / N	Have YOU had Uterine (Endometrial) or Colorectal cancer BEFORE age 50						
Y / N	TWO or more Lynch Syndrome cancers** on the same side of the family, 1 under age 50						
Y / N	THREE or more Lynch Syndrome cancers** on the same side of the family at ANY age						

Lynch Syndrome cancers include: Colon/Colorectal, Uterine/Endometrial, Ovarian, and Gastric/Stomach cancer

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Testing? ☐ YES ☐ NO ☐ MORE INFORMATION NEEDED

If YES, Patient chose to: ☐ ACCEPT ☐ DECLINE

If MORE INFORMATION NEEDED, Follow-up appointment scheduled: Date:_____

PATIENT SIGNATURE for declined testing:_____ **Date:**_____

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