Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name	Date of Birth	Age

Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close bood relatives should be considered: *You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents,Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great-Grandchildren*

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU Age of Diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of Diagnosis	RELATIVES on your MOTHER'S SIDE	Age of Diagnosis	RELATIVES on your FATHER'S SIDE	Age of Diagnosis
☒ Y ☐ N	***Example: Breast Cancer***	***45***	------	------	***Aunt Cousin***	***45 61***	***Grandmother***	***53***
☐ Y ☐ N	Breast cancer *(Female or Male)*							
☐ Y ☐ N	Ovarian cancer *(Peritoneal/Fallopian tube)*							
☐ Y ☐ N	Endometrial (*Uterine*) cancer							
☐ Y ☐ N	Colon/rectal cancer							
☐ Y ☐ N	10 or more Lifetime Colon/ Rectal Polyps *(Specify #)*							
☐ Y ☐ N	Pancreatic cancer							
☐ Y ☐ N	Prostate cancer							
☐ Y ☐ N	Other Cancer(s) *(Specify cancer type)*	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate						
☐ Y ☐ N	Are you of Ashkenazi Jewish descent?							
☐ Y ☐ N	Are you concerned about your personal and/or family history of cancer?							
☐ Y ☐ N	Have your or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible) If Yes, Who? ______ What gene(s)? ______ What was the result? ______							

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) ______ **Your current weight** (lbs) ______

Your menopausal status:

☐ Pre-menopausal

☐ Peri-menopausal (time before menopause marked by irregular cycles)

☐ Post-menopausal: Age of onset ______ (permanent cessation of period for 12 months or longer)

Your age at time of first menstrual period ______

Your age at time of first live birth ______

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ unknown

If yes, are you a: ☐ Current user: How many years ago did you start? ______ Intend to use for ______ more years

☐ Past user: How many years ago did you stop using? ______

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? ______

Number of daughters ______ **Number of sisters** ______

Number of maternal aunts (mother's sisters) ______

Number of paternal aunts (father's sisters) ______

HEREDITARY CANCER RED FLAGS (complete with your healthcare provider)

Personal and/or family history of any one of the following (check all that apply):

MULTIPLE: A combination of cancers on the same side of the family:

☐ **2 or more:** breast / ovarian / prostate / pancreatic cancer

☐ **2 or more:** colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)

☐ **2 or more:** melanoma / pancreatic

YOUNG: Any 1 of the following at age **50 or younger:**

☐ Breast cancer ☐ Colon/rectal cancer ☐ Endometrial cancer

RARE: Any 1 of these rare presentations at **any age:**

☐ Ovarian cancer (Peritoneal/Fallopian tube)

☐ Breast: Male breast cancer or Triple negative breast cancer (ER-, PR-, HER2- Pathology)

☐ Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology**

☐ Endometrial cancer with abnormal MSI/IHC

☐ 10 or more colon/rectal polyps*

Certain ancestries such as Ashkenazi Jewish, may have greater risk for hereditary cancer syndromes

***Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type*

Assessment criteria based on medical society guidelines. For medical society guidelines, go to MyriadPro.com

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

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

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Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

If yes and accepted, which test? ☐ BRAC*Analysis*® with Myriad myRisk® ☐ Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS®PLUS with Myriad myRisk ☐ COLARIS *AP*®PLUS with Myriad myRisk ☐ Single Site Testing ☐ Myriad myRisk Update

☐ Other: ______

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Next Appointment: ______

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