Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Physician:** _____

Date Completed: _____

Please mark below if there is a ***personal or family history*** of any of the following cancers. If yes, then indicate family relationship and ***age at diagnosis*** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
For example: Colorectal cancer		Brother 36 yrs	Aunt 44 yrs Cousin 58 yrs	Grandfather 65 yrs
BREAST AND OVARIAN CANCER				
Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish descent?				
COLON AND UTERINE CANCER				
Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more cumulative colon polyps				
MELANOMA				
Melanoma				
Pancreatic cancer				
OTHER CANCER				
_____				

FOR OFFICE USE ONLY

- ☐ Patient appropriate for further risk assessment and/or genetic testing
  - ☐ BRAC*Analysis*® – A test for Hereditary Breast and Ovarian Cancer
  - ☐ COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
  - ☐ COLARIS *AP*® – A test for Adenomatous Polyposis Syndromes
  - ☐ MELARIS® – A test for Hereditary Melanoma
- ☐ Discussed hereditary cancer risk with patient
- ☐ Patient offered genetic testing
  - ☐ ACCEPTED ☐ DECLINED
- ☐ Follow up appointment scheduled
  Date: _____

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