Family History Questionnaire for Common Hereditary Cancer Syndromes

This is a screening tool for the common features of hereditary cancer syndromes. Based on the family history information you provide here, you MAY be appropriate for genetic testing and your provider may be able to change your medical management to improve your care.

Instructions: Please circle yes to those that apply to you and/or your family. Please consider these family members when completing the form (Both Maternal AND Paternal sides of the family):

Mother/Father/Sister/Brother/Children = **1st Degree Blood Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Blood Relatives**

			Specify Relative(s):	**Age of Diagnosis:**
Breast Cancer before age 50	Yes	No	_____	_____
Ovarian Cancer at any age	Yes	No	_____	_____
Breast Cancer in both breasts (Bilateral)	Yes	No	_____	_____
3 Breast Cancers on the same side of the family (at any age)	Yes	No	_____	_____
Male Breast Cancer	Yes	No	_____	_____
"Triple Negative" Breast Cancer under 60	Yes	No	_____	_____
Uterine Cancer before age 50	Yes	No	_____	_____
Colorectal Cancer before age 50	Yes	No	_____	_____
3 or more of the following cancers on the same side of the family: Uterine, Colorectal, Ovarian, Stomach	Yes	No	_____	_____
Ashkenazi Jewish Ancestry with breast, ovarian, and/or pancreatic cancer in the family at any age?	Yes	No	_____	_____
Family members who have tested positive for the BRCA gene, Lynch Syndrome gene, or any others	Yes	No	_____	_____

_____ _____
Patient Signature Date

_____ _____
Patient Name Printed Date of Birth

For Office Use Only

Patient is a candidate for genetic testing: **Yes** **No**

___ Genetic testing information provided
___ Genetic testing completed
___ Genetic testing Declined

_____
Provider Name

_____
Provider Signature