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	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? _____							

HEREDITARY CANCER RED FLAGS (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or Family history† of:

- ○ *Breast cancer diagnosed at/under age 50*
- ○ *Ovarian (peritoneal/fallopian tube) cancer at any age*
- ○ *Two or more primary breast cancers≠*
- ○ *Male breast cancer at any age*
- ○ *Triple Negative Breast Cancer (ER-, PR-, HER2-Pathology)*
- ○ *Ashkenazi Jewish ancestry with an HBOC-associated cancer≠§*
- ○ *Three or more HBOC-associated cancers at any age≠§*
- ○ *A previously identified HBOC syndrome mutation in the family*

† *Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage*
≠ *In the same individual or on the same side of the family*
§ *HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score ≥ 7)*

Lynch Syndrome - Red Flags*

An individual with a personal history of any of the following:

- ○ *Colon/rectal and/or endometrial cancer before age 50*
- ○ *MSI High histology on a colon/rectal or endometrial tumor before age 60¶*
- ○ *Abnormal MSI/IHC tumor test result (colon/rectal/endometrial)*
- ○ *Two or more Lynch syndrome cancers** at any age*
- ○ *Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^*
- ○ *A previously identified Lynch syndrome or MAP syndrome mutation in the family*

An individual with a family history of any of the following:

- ○ *A first-or second-degree relative with colon/rectal or endometrial cancer before age 50*
- ○ *Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^*
- ○ *Three or more relatives with a Lynch syndrome cancer** at any age^*
- ○ *A previously identified Lynch syndrome or MAP syndrome mutation in the family*

¶ *MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern*
** *Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*
^ *Cancer history should be on the same side of the family*

• *Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.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, 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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