Risk Assessment for Hereditary Cancer Syndrome

INSTRUCTIONS: **Please circle YES (Y)** 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.

Consider the following family members on both your MOTHER'S and FATHER'S sides:

You – Your Mother – Your Father – Your Brothers & Sisters – Your Children – Your 1st Cousins – Your Nieces & Nephews
Your Father's Brothers & Sisters and your Mother's Brothers & Sisters (Your Aunts and Uncles)
Your Father's Parents and your Mother's Parents (Your Grandmother & Grandfather) – Your Great Grandparents

Your Name:_____ **Date of Birth:**_____ **Your Doctor:**_____ **Date of Visit:**_____

	BREAST AND OVARIAN CANCER	You or Siblings	AGE	Mother's Side	AGE	Father's Side	AGE
Y / N	**Have YOU had breast cancer at or before age 50**			**N/A**	**N/A**	**N/A**	**N/A**
Y / N	**Your MOTHER, SISTER, DAUGHTER, GRANDMOTHER, AUNT, or NIECE diagnosed with breast cancer at or before age 45**						
Y / N	**2 or more breast cancers on the same side of the family, 1 BEFORE age 50**						
Y / N	**3 or more breast cancers on the same side of the family, at ANY age**						
Y / N	**Ovarian Cancer in your family, at ANY age**						
Y / N	**Male Breast Cancer in your family, at ANY age**						
Y / N	**Triple Negative Breast Cancer in the family**						
Y / N	**3 or more of the following cancers on the same side of the family, at ANY age (breast, ovarian, prostate, or pancreatic)**						
Y / N	**Ashkenazi Jewish ancestry with ANY breast, ovarian or pancreatic cancer in the family**						
Y / N	**Is there a known BRCA Mutation in the family**						
Y / N	**Have you been tested for a BRCA mutation**						

	COLON AND UTERINE CANCER	You or Siblings	AGE	Mother's Side	AGE	Father's Side	AGE
Y / N	**Have YOU had COLORECTAL (Colon) or UTERINE (Endometrial) cancer at or before age 50**			**N/A**	**N/A**	**N/A**	**N/A**
Y / N	**2 or more COLORECTAL (Colon) CANCERS on the same side of the family, 1 BEFORE age 50**						
Y / N	**1 COLORECTAL CANCER AND 1 or more LYNCH SYNDROME CANCER (listed below) on the same side of the family, 1 BEFORE age 50**						
Y / N	**3 or more LYNCH SYNDROME CANCERS (listed below) on the same side of the family**						

***Lynch Syndrome Cancers: Colorectal, Uterine/Endometrial, Ovarian, Gastric, Stomach, Pancreatic, Ureter, Bladder, & Brain**

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:**_____