Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth: _____ Date completed: _____

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's** or **father's side**). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

			RELATIONSHIP	AGE AT DIAGNOSIS
BREAST AND OVARIAN CANCER				
Y	N	-Breast cancer before age 50		
Y	N	-Ovarian cancer		
Y	N	-Breast cancer in both breasts or multiple primary breast cancers		
Y	N	-Both breast & ovarian cancer (in an individual or family)		
Y	N	-Male breast cancer		
Y	N	-2 or more breast or ovarian cancers (in an individual or a family)		
Y	N	-Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		
COLON AND UTERINE CANCER				
Y	N	-Uterine cancer before age 50		
Y	N	-Colorectal cancer before age 50		
Y	N	-Both uterine & colorectal cancer (in an individual or family)		
Y	N	-2 or more uterine or colorectal cancers (in an individual or a family)		
Y	N	-Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)		
Y	N	-10 or more colon polyps found in a lifetime		

candidate for further risk assessment and/or genetic testing

Information given to patient to review

Follow up appointment scheduled Date: _____

Patient offered genetic testing

Accepted Declined

_____ _____

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