Family History of Cancer Questionnaire

Name: ______________________________ **Date:** ____________________

Please circle Y to those that apply to **YOU and/or YOUR FAMILY** (on both **MOTHER and FATHER'S** side.)
Please list your relationship to the individual diagnosed and the age at cancer diagnosis.

Consider parents, siblings, grandparents, aunts, uncles and chilren.

HEREDITARY BREAST and OVARIAN CANCER SYNDROME

		Relationship	Age at Diagnosis
Breast cancer before age 50	Y N	____________	____________
Ovarian cancer at any age	Y N	____________	____________
Breast cancer in both breast or multiple primary breast cancers at any age	Y N	____________	____________
Male breast cancer at any Age	Y N	____________	____________
3 or more breast cancers on the same side of the family at any age	Y N	____________	____________
Ashkenazi Jewish with a personal or family history of breast or ovarian cancer at any age	Y N	____________	____________

LYNCH SYNDROME / HEREDITARY NONPOLYPOSIS COLORECTAL CANCER

Endometrial (uterine) cancer before age 50	Y N	____________	____________
Colorectal cancer before age 50	Y N	____________	____________
Colorectal cancer at any age AND another family member with any cancer listed below at any age	Y N	____________	____________

Colorectal, Endometrial, Ovarian, Stomach, Kidney/Urinary Tract, Brain or Small Bowel

If you Circled yes to one or more statements on the Family History Questionnaire, you may be appropriate for a blood test to help determine if you have an inherited risk of cancer

O Patient offered genetic testing
O Accepted O Declined

O Information given to patient for review
O Follow up appointment scheduled for date ____________

Signature: ______________________________ Date ______________________________