We are committed to your health and cancer prevention.
To best serve you, we need a detailed personal and family cancer history.
Please fill out the back of this form.
If you have questions please ask!

If you filled this out within the last 6 months and nothing has changed, you do not need to fill it out again. Just SIGN it and indicate as such on the form.

THANK YOU!

If you have already had genetic testing for a hereditary cancer syndrome (BRCA) and your family history has not changed, you do not need to complete this form

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____ Age: _____

Has anyone in your family had genetic testing for a hereditary cancer syndrome? (Ex: BRCA or Lynch)? Yes or No

Please mark below if there is a **personal or family history** of any of the following cancers and **indicate family relationship** and **AGE at diagnosis** in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) *Ex: Brother 36 yrs*	Mother's Side (Who + age at diagnosis) *Ex: Aunt 44 yrs*	Father's Side (Who + age at diagnosis)
Y	**N**	Breast cancer (please note if it was triple neg)				
Y	**N**	Breast cancer in both breasts OR multiple primary breast cancers				
Y	**N**	Ovarian/fallopian tube cancer				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Jewish decent?				

COLON AND UTERINE CANCER (Colaris)

Y	**N**	Uterine (endometrial) cancer				
Y	**N**	Colon cancer				
Y	**N**	Ovarian, stomach, biliary tract, kidney/urinary tract, brain OR small bowel cancer				
Y	**N**	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	**N**	Prostate Cancer (BRCA)				
Y	**N**	Pancreatic Cancer (Col/BRCA)				
Y	**N**	Melanoma				

Patient's Signature:_____ Date: _____

For Office Use Only:

BRCA/Lynch Testing Indicated?: YES NO

Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED

Follow-up appointment scheduled: YES NO Date of Appointment:_____

One person with (out to 2nd degree):	**BRCA – Personal or Fam. History**	**Lynch Syndrome (Colon/Endo)**
• Breast Cancer at 49 or younger • Ovarian Cancer at any age • Male breast cancer any age • Pancreatic cancer any age • Bilateral Breast at any age • Metastatic prostate cancer at any age • Triple Neg Br.Ca. at 60 or younger • Jewish ancestry w/ovarian, pancreatic or breast cancer any age • Personally affected w/breast cancer at any age	Two persons with (out to 3rd Degree) • 2 Breast Cancers, w 1 ≤ 50 or younger Three Persons with (out to 3rd degree) • Breast and/or Ovarian and/or Pancreatic (any age)/aggressive Prostate	Personally affected with: • Colon or Endometrial at ≤ 64 Family History out to 2nd Degree: • 1 Colon or Endometrial Cancer ≤ 49 • 10+ Colon polyps found in a lifetime • 2 or more Lynch* cancers in the same person • 2 or more Lynch* cancers w/1 dx < 50 *(gastric, ovarian, brain, kidney, small bowel, pancreas, ureter, biliary tract)

MD Signature: _____ Date: _____