FAMILY HISTORY OF CANCER QUESTIONNAIRE

Name ____ Date ________________________

Please circle Y to those that apply to ***YOU and/or YOUR FAMILY*** (on both your mother OR father's side). Please notate your relationship to the individual diagnosed (ex. Self, mother, paternal aunt, maternal grandmother, sister) and their age when diagnosed with cancer.

HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

			Relationship	Age at Diagnosis
Y	N	Breast cancer before age 50	____________________	______________
Y	N	Ovarian cancer at any age	____________________	______________
Y	N	Breast cancer in both breasts or multiple primary breast cancers at any age	____________________	______________
Y	N	Both breast & ovarian cancer (in an individual ***OR*** family 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	____________________	______________

LYNCH SYNDROME / HEREDITARY NONPOLYPOSIS COLORECTAL CANCER

			Relationship	Age at Diagnosis
Y	N	Endometrial (uterine) cancer before age 50	____________________	______________
Y	N	Colorectal cancer before age 50	____________________	______________
Y	N	Colorectal cancer after age 50 ***AND*** a family member with any cancer below: 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.

○ Patient offered genetic testing
○ Accepted ○ Declined

○ Information given to patient for review
○ Follow up appointment scheduled for
____

____

Signature Date