Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________________ **Date of Birth:** ______________ **Age:** ________
Height: _______ Weight: _______ Age of First Period: ________ Your Age When First Child Delivered (If applicable): ________ Age of Your Mother: ________
Are you Menopausal: _______ Have you ever used hormone replacement therapy? Please circle **Yes** or **No** If Yes, how long have you been it? ____________
Has anyone in your family had genetic testing for hereditary cancer syndrome (Ex: BRCA or LYNCH)? Please circle **Yes** or **No** If Yes, what was the result? _____
Best Contact Phone Number(s): ______________________________ Email: ______________________________

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

Please circle			**You (age at diagnosis)**	**Siblings/Children (Who + age at diagnosis)** ***Ex: Brother, 36 yrs***	**Your Mother's side (Who + age at diagnosis)** ***Ex: Aunt, 44 yrs***	**Your father's side (Who + age at diagnosis)** ***Ex: Grandpa, 65 yrs***
Y	**N**	Breast cancer				
Y	**N**	Breast cancer in both breasts or multiple primary breast cancers				
Y	**N**	Ovarian cancer				
Y	**N**	Male breast cancer				
Y	**N**	Are you of Ashkenazi Jewish descent				
Y	**N**	Uterine (endometrial) cancer (*NOTE: do not include cervical cancer*)				
Y	**N**	Colon cancer				
Y	**N**	Stomach, kidney/urinary tract, brain, or small bowel/intestinal cancer *(NOTE: Please circle or write appropriate cancer in column)*				
Y	**N**	10 or more colon polyps found in a lifetime				
Y	**N**	Prostate cancer				
Y	**N**	Pancreatic cancer (Col/BRCA)				
Y	**N**	Malignant melanoma				

Patient's Signature: ______________________________ **Date:** ______________

For Office Use Only

BRCA/Lynch/myRisk Testing Indicated? **Yes** **No**

Patient offered hereditary cancer testing? **Yes** **No** If YES: **ACCEPTED** **DECLINED:**______________

Follow-up appointment scheduled? **Yes** **No** Date of Appointment: ______________

Provider Signature: ______________________________ **Date:** ______________

BRCA - Personal or Fam History

One person with (out to 2nd degree)

- Breast cancer at 45 or younger
- Ovarian cancer at any age
- Male breast cancer at any age
- Breast cancer + Jewish Heritage
- Bilateral Breast cancer at 50 or younger
- Triple negative breast cancer at any age
- Family history of known BRCA1 or BRCA2 mutations

BRCA - Personal or Fam History

Two persons with (out to 3rd degree)

- 2 breast cancers w/ 1 ≤ 50 yrs
- Breast & ovarian cancer (any age)

Three persons with (out to 3rd degree)

- Breast and/or Ovarian and/or Pancreatic (any age) and/or aggressive prostate cancer

Lynch Syndrome (Colon/Endometrial)

Personally affected with:

- Colon and/or Endometrial cancer at ≤ 50 yrs
- Family history of known Lynch mutations

Family History of Colon, Endometrial, or Lynch Cancers (out to 2nd degree) (ie. Gastric, ovarian, brain, kidney, small bowel)

- 1 or more Lynch cancers, 1 dx ≤ 50 yrs

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 by writing, “No changes.”

THANK YOU!