

Cancer Family History Questionnaire

Personal Information

Patient Name: _____ Date of Birth: _____ Age: _____
 Gender (M/F): _____ Today's Date(MM/DD/YY): _____ Health Care Provider: _____

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.

If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	<input checked="" type="radio"/> Y <input type="radio"/> N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer at or before age 49	<input type="radio"/> Y <input type="radio"/> N				
2 or more separate breast cancers in one person, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
2 or more people in my family (can include me) with breast cancer, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				
Ovarian cancer at any age	<input type="radio"/> Y <input type="radio"/> N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	<input type="radio"/> Y <input type="radio"/> N				
3 or more of these cancers on same side of the family at any age: pancreatic, breast, or aggressive prostate* *Gleason Score ≥7	<input type="radio"/> Y <input type="radio"/> N				
Male breast cancer at any age	<input type="radio"/> Y <input type="radio"/> N				
Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age	<input type="radio"/> Y <input type="radio"/> N				
Pancreatic cancer or aggressive prostate cancer OR one relative with breast cancer at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N				

Colon/rectal or Endometrial (uterine) cancer before age 50	<input type="radio"/> Y <input type="radio"/> N				
Personal history of Endometrial (uterine) cancer at any age†	<input type="radio"/> Y <input type="radio"/> N				
TWO individuals on the same side of my family (can include me): at least 1 with colon/rectal or endometrial (uterine) cancer at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	<input type="radio"/> Y <input type="radio"/> N				
THREE OR MORE individuals on the same side of my family (can include me) with a Lynch-associated* cancer at any age, with at least 1 being a colon/rectal or endometrial (uterine) cancer	<input type="radio"/> Y <input type="radio"/> N				

† PREMM_{1,2,6} Score ≥ 5%

* Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).

Have you or a family member had genetic testing for a hereditary cancer syndrome? Y N If yes, Who? _____ What gene(s)? _____
 What was the result? _____

Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

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

OFFICE USE ONLY: Below to be completed by your Medical Assistant

GENETIC EDUCATION PROVIDED (circle): Y N Patient watched video Y N Test Sent Y N Declined Testing

MEDICAL ASSISTANT SIGNATURE _____