

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date Completed: _____

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

	YOU	SIBLINGS/ CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
<i>For example:</i> Colorectal cancer		<i>Brother 36 yrs</i>	<i>Aunt 44 yrs Cousin 58 yrs</i>	<i>Grandfather 65 yrs</i>

BREAST AND OVARIAN CANCER

Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

Uterine (endometrial) cancer				
Colorectal cancer				
Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer				
10 or more colon polyps				

MELANOMA

Melanoma				
Pancreatic cancer				

OTHER CANCER

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FOR OFFICE USE ONLY

- Patient appropriate for further risk assessment and/or genetic testing
- BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer
 - COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
 - COLARIS AP® – A test for Adenomatous Polyposis Syndromes
 - MELARIS® – A test for Hereditary Melanoma

- Patient given information to review
- Patient offered genetic testing
- ACCEPTED DECLINED
- Follow up appointment scheduled
- Date: _____