

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____

Physician: _____

Date of Birth: _____

Date completed: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. Please circle Y to all statements below that apply to YOU or YOUR FAMILY (including your **mother's and father's families**). Following each Y circled, please list your relationship to the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and age at diagnosis. You may list the same cancer diagnosis more than once as you answer these questions.

| | | <u>RELATIONSHIP</u> | <u>AGE AT DIAGNOSIS</u> |
|---|---|--|-------------------------|
| <u>BREAST AND OVARIAN CANCER</u> | | | |
| Y | N | Breast cancer before age 50 | _____ |
| Y | N | Ovarian cancer | _____ |
| Y | N | Breast cancer in both breasts or multiple primary breast cancers | _____ |
| Y | N | Both breast & ovarian cancer (in an individual or family) | _____ |
| Y | N | Male breast cancer | _____ |
| Y | N | 2 or more breast or ovarian cancers (in an individual or family) | _____ |
| Y | N | Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer | _____ |

| | | | |
|--|---|---|-------|
| <u>COLON AND UTERINE CANCER</u> | | | |
| Y | N | Uterine cancer before age 60 | _____ |
| Y | N | Colorectal cancer before age 60 | _____ |
| Y | N | Both uterine & colorectal cancer (in an individual or family) | _____ |
| Y | N | 2 or more uterine or colorectal cancers (in an individual or family) | _____ |
| Y | N | Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family) | _____ |
| Y | N | 10 or more colon polyps found in a lifetime | _____ |

If you circled Y to any statements above, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

| | |
|---|---|
| <input type="checkbox"/> Candidate for further risk assessment and/or genetic testing <input type="checkbox"/> Information given to patient to review <input type="checkbox"/> Follow up appointment scheduled Date: _____ | <input type="checkbox"/> Patient offered genetic testing <input type="checkbox"/> Accepted <input type="checkbox"/> Declined |
|---|---|

Patient's Signature

Date

Health Care Provider's Signature

Date