

CANCER FAMILY HISTORY QUESTIONNAIRE

Personal Information

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

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE: BREAST CANCER	45	-----	---	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE/ENDOMETRIAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME COLON POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

Y N Are you of Ashkenazi Jewish descent?

Y N Are you concerned about your personal and/or family history of cancer?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Your PERSONAL History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- Breast cancer diagnosed at age 50 or younger
- Ovarian cancer at any age
- Two primary occurrences of breast cancer
- Male breast cancer
- Triple Negative Breast Cancer
- Pancreatic cancer with a breast or ovarian cancer
- Ashkenazi Jewish ancestry with an HBOC-associated cancer*

Lynch Syndrome** (see cancer list below)

- Colorectal cancer under age 50
- Endometrial/uterine cancer under age 50
- MSI High histology*** before age 60
- Abnormal MSI/IHC tumor test result (colon/rectal/endometrial/uterine)
- Two or more Lynch syndrome cancers** at any age
- YOU and one or more relatives with a Lynch syndrome cancer**

*HBOC associated cancer includes: Breast, ovarian, and pancreatic cancer

**Lynch syndrome cancer includes: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas

***MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, crohn's-like lymphocytic reaction histology, or medullary growth pattern

Your FAMILY History – Red Flags

Hereditary Breast and Ovarian Cancer Syndrome

- Close relative with breast cancer less than age 50
- Close relative with ovarian cancer at any age
- Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- A male relative with breast cancer
- Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.
- Three or more relatives with breast cancer at any age
- A previously identified BRCA1 or BRCA2 mutation in the family

Lynch Syndrome** (see cancer list below)

- Two or more relatives with a Lynch syndrome cancer**, one before the age of 50
- Three or more relatives with a Lynch syndrome cancer** at any age
- A previously identified Lynch syndrome mutation in the family

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

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

Follow-up appointment scheduled: YES NO Date of Next Appointment: _____