Family History Questionnaire

Patient Name: ______________________________ Physician Seeing Today: ______________________
Date of Birth: ____________________ Age: ______________ Today's Date: ______________________

This is a screening tool for cancers that run in families. Please consider these family members when completing:
1st Degree Relatives = Mother / Father / Sister / Brother / Children
AND 2nd Degree Relatives = Aunt / Uncle / Grandparent / Niece / Nephew

Have you or any of your relatives had cancer genetic testing? **YES** **NO** Explain:______________________________

Yes/No		**BREAST / OVARIAN CANCER** (HBOC/BRAC Analysis)	**SELF SIBLINGS CHILDREN**	**MOTHER'S SIDE**	**FATHER'S SIDE**	**Age of** Diagnosis
Y	N	***EXAMPLE: Breast cancer diagnosed before age 50***		***Mother***		***47***
Y	**N**	**Breast cancer diagnosed before age 50**				
Y	**N**	**Ovarian cancer** at any age				
Y	**N**	**THREE relatives** on the same side of the family with **breast cancer at any age** (please also include 3rd degree relatives: cousins and great relatives)				
Y	**N**	**Multiple breast cancers** in the same person (in the same breast or in both breasts)				
Y	**N**	**Male breast cancer** at any age				
Y	**N**	**Ashkenazi Jewish ancestry** with a breast, ovarian or pancreatic cancer in the family at any age				

Yes/No		**COLON / UTERINE CANCER** (Lynch Syndrome/Colaris)	**SELF SIBLINGS CHILDREN**	**MOTHER'S SIDE**	**FATHER'S SIDE**	**Age of** Diagnosis
Y	**N**	Have **YOU** been diagnosed with **colon** or **uterine** (endometrial) cancer or **before age 50**				
Y	**N**	**TWO or more relatives** on the same side of the family w/ any of the following, **one diagnosed before age 50**: *Colon, Uterine/Endometrial, Ovarian, Stomach*				
Y	**N**	**THREE or more relatives** on the same side of the family w/ any of the following, diagnosed **at any age**: *Colon, Uterine/Endometrial, Ovarian, Stomach*				

Any other cancer in you or any family members? (*Ex: Prostate, Pancreatic, Melanoma, >10 colon polyps, Brain, Sebaceous Adenomas, etc.):*
Please list RELATIVE, CANCER SITE and AGE of diagnosis:

FOR OFFICE USE ONLY

- ☐ Patient **is** appropriate for hereditary cancer genetic testing ☐ Patient **not** appropriate
- ☐ Patient counseled/offered hereditary cancer genetic testing: ☐ ACCEPTED or ☐ DECLINED

HCP Signature:______________________________ **Patient Signature:** ______________________________