CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name: _____ Physician (today's visit): _____
Date of Birth: _____ Today's Date: _____

This is a screening tool for cancers that run in families. Please consider these family members when completing the form and answer each question separately:
Mother/Father/Sister/Brother/Children
Aunt/Uncle/Grandparent/Niece/Nephew/ 1st Cousin

Please only circle yes if your history exactly matches the questions on this form.

		Cancer Family History	SELF	Please list your FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast Cancer diagnosed at age 49 or less				
Y	N	Ovarian Cancer at any age				
Y	N	Two breast cancers diagnosed on the same side of the family, 1 diagnosed at age 50 or less				
Y	N	Three relatives on the same side of the family with Breast , Ovarian or Prostate Cancer at any age				
Y	N	Ashkenazi Jewish ancestry with one breast, ovarian or pancreatic cancer in the family				
Y	N	Male breast cancer at any age or Pancreatic Cancer at any age				
Y	N	Endometrial/Uterine Cancer diagnosed before 50				
Y	N	Colon Cancer diagnosed before age 50				
Y	N	Three or more of the following cancers on the same side the family at any age: Colon, Endometrial, Ovarian, Gastric/Stomach, Pancreatic, Brain, Small Bowel, Renal/Pelvic				
Y	N	**20 or more colon/rectal polyps found in 1 person throughout their lifetime. Specify number _____**				
Have you ever been tested for BRCA or Lynch Syndrome before? Yes or No						

Patient Signature_____

FOR OFFICE USE ONLY

€ Patient is NOT appropriate for testing
€ Patient is appropriate for testing

Patient offered genetic testing: Accepted OR Declined

HCP Signature: _____