

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____

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.

BREAST AND OVARIAN CANCER

			You	Siblings / Children	Mother's Side	Father's Side
<input checked="" type="radio"/>	N	<i>Example: Colon Cancer</i>		<i>Brother, 36 yrs</i>	<i>Aunt, 44 yrs</i>	<i>Grandfather, 65 yrs Cousin, 58 yrs</i>
<input type="radio"/>	N	Breast cancer				
<input type="radio"/>	N	Ovarian cancer				
<input type="radio"/>	N	Breast cancer in both breasts OR multiple primary breast cancers				
<input type="radio"/>	N	Male breast cancer	N/A			
<input type="radio"/>	N	Are you of Ashkenazi Jewish descent?				

ABDOMINAL - PELVIC CANCERS:

			You	Siblings / Children	Mother's Side	Father's Side
<input type="radio"/>	N	Uterine (endometrial) cancer				
<input type="radio"/>	N	Colon cancer				
<input type="radio"/>	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
<input type="radio"/>	N	Prostate cancer	N/A			
<input type="radio"/>	N	Pancreatic cancer				
<input type="radio"/>	N	10 or more colon polyps found in a lifetime				

SKIN CANCER:

			You	Siblings / Children	Mother's Side	Father's Side
<input type="radio"/>	N	Melanoma				
<input type="radio"/>	N	Other skin cancer				

OTHER CANCERS

		Type of cancer	You	Siblings / Children	Mother's Side	Father's Side
<input type="radio"/>	N					

For Office Use Only:

Patient offered genetic testing: **ACCEPTED** **DECLINED**

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____