

# Cancer Family History Questionnaire

## Personal Information

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

Please mark "Yes" or "No" below if there is a personal or family history of any of the following cancers.  
 (If yes, list in the section below who in your family was diagnosed and at what age)

Breast cancer at or before age 45	<input type="radio"/> Y <input type="radio"/> N	20 or more lifetime colon/rectal polyps found in 1 person. Specify number _____	<input type="radio"/> Y <input type="radio"/> N
2 or more separate breast cancers in one person, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N	Colon/rectal or endometrial (uterine) cancer before age 50	<input type="radio"/> Y <input type="radio"/> N
2 or more people in my family (can include me) with breast cancer, one at age 50 or younger	<input type="radio"/> Y <input type="radio"/> N	Personal history of endometrial (uterine) cancer at any age <sup>f</sup>	<input type="radio"/> Y <input type="radio"/> N
Ovarian (peritoneal/fallopian tube) cancer at any age	<input type="radio"/> Y <input type="radio"/> N	2 individuals in my family (can include me): at least one with colon/rectal or endometrial (uterine) cancer at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	<input type="radio"/> Y <input type="radio"/> N
Triple negative breast cancer at age 60 or younger (ER-, PR-, HER2 - Pathology)	<input type="radio"/> Y <input type="radio"/> N	THREE OR MORE individuals in my family (can include me) with a Lynch-associated* cancer at any age, with at least 1 being a colon/rectal or endometrial (uterine) cancer	<input type="radio"/> Y <input type="radio"/> N
Three or more of these cancers on same side of the family at any age: pancreatic, breast, or aggressive prostate*	<input type="radio"/> Y <input type="radio"/> N	<small>#PREMM<sub>1,2,4</sub> Score ≥ 5%</small>	<input type="radio"/> Y <input type="radio"/> N
Male breast cancer at any age	<input type="radio"/> Y <input type="radio"/> N	<small>*Lynch-associated cancers include: colon, endometrial (uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).</small>	<input type="radio"/> Y <input type="radio"/> N
Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age	<input type="radio"/> Y <input type="radio"/> N	Have you or a family member had genetic testing for a hereditary cancer syndrome? If yes, Who? _____ What gene(s)? _____	<input type="radio"/> Y <input type="radio"/> N
Pancreatic cancer or aggressive prostate cancer* and one relative with breast cancer at age 50 or younger <small>*Gleason Score ≥ 7</small>	<input type="radio"/> Y <input type="radio"/> N	What was the result? _____	<input type="radio"/> Y <input type="radio"/> N

You and Your Family's Cancer History. (Please be as thorough and accurate as possible)  
 Include both sides of your family and list each member separately: You, parents, children, brothers, sisters, half-siblings, grandparents, grandchildren, aunts, uncles, nieces, nephews.

Cancer	You: Age of Dx	Siblings/ Children	Age of Dx	Mother's Side	Age of Dx	Father's Side	Age of Dx
<b>EXAMPLE:</b> Breast cancer	45	Sister	55	Maternal Aunt #1 Maternal Aunt #2	65 45	Paternal Grandma	53
Breast Cancer (male or female)							
Ovarian Cancer (peritoneal/fallopian tube)							
Endometrial (uterine) Cancer							
Colon/Rectal Cancer							
20 or more Lifetime Colon/Rectal Polyps (specify #)							
Other Cancers (specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

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

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Office Use Only:

Patient offered hereditary cancer genetic testing?  YES  NO  ACCEPTED  DECLINED  
 If YES, which test?  BRACAnalysis\* with Myriad myRisk\*  Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk  
 COLARIS\*PLUS with Myriad myRisk  COLARIS AP\*PLUS with Myriad myRisk  Single Site Testing  Myriad myRisk Update  Other: \_\_\_\_\_  
 Follow-up appointment scheduled:  YES  NO Date of Next Appointment: \_\_\_\_\_