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

*Only circle YES if your history exactly matches these questions. You will have an opportunity to inform the nurse of other cancers in your family.

*If you are unsure of the exact age of diagnosis please indicate whether the diagnosis was above or below the age of 50 by writing 45 for below 50 diagnoses and 55 for above 50 diagnoses.

		Cancer Family History	SELF	Please list your FAMILY MEMBER w/ CANCER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Colon Cancer diagnosed before age 50				
Y	N	Endometrial/Uterine 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	Breast Cancer diagnosed at age 45 or less				
Y	N	Ovarian Cancer at any age				
Y	N	Two relatives on the same side of the family (could include yourself) with breast cancer, one of whom was diagnosed at age 50 or less				
Y	N	Three relatives on the same side of the family (could include yourself) with Breast and or Ovarian Cancer at any age				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with one breast, ovarian or pancreatic cancer in the family (could include yourself)				
Have you ever been tested for BRCA or Lynch Syndrome before?						

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: _____