Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth: _____ Today's Date: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) to any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the age of diagnosis and relationship of family member with cancer.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**

		COLON AND UTERINE CANCER	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) cancer at any age				
Y	N	Colorectal cancer at any age				
Y	N	Two or more of the following cancers on the same side of the family: ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	N	A family member with a known Lynch Syndrome mutation				
Y	N	10 or more colon polyps found in a lifetime				

		BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast cancer at any age				
Y	N	Ovarian cancer at any age				
Y	N	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	N	Three relatives on the same side of the family with breast cancer at any age				
Y	N	Triple negative breast cancer under the age of 60 (ER, PR and HER2 negative receptor status)				
Y	N	Male breast cancer at any age				
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	N	A family member with a known BRCA mutation				

Is there any other cancer in you or any family members not listed above? If yes, provide site, relationship and age:

_____

_____

☐ Patient is **NOT** appropriate for further risk assessment and/or genetic testing at this time
☐ Patient is appropriate for further risk assessment and/or genetic testing
☐ Information given to patient to review
☐ Follow-up appointment scheduled on _____
(date)

At this time, I will (CHECK 1): □ undergo testing □ schedule another visit and review info before deciding □ decline testing
I acknowledge that I (CHECK 1) □ was counseled / □ received information / □ received recommendation for hereditary cancer syndrome testing. I understand and accept that it is my responsibility to review and consider information, to make an informed decision about hereditary cancer syndrome testing, and to inform this physician of my decision.

Patient Signature_____ **HCP Signature**_____ **Date**_____