YOUR FAMILY HISTORY IS IMPORTANT TO US

YOUR PHYSICIAN WILL BE USING THIS INFORMATION TO PERFORM AN ACCURATE ASSESSMENT OF YOUR CANCER RISKS

PLEASE TAKE CARE WHEN COMPLETING IT

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

Instructions: **Please circle "Y"** to below statements that apply to **YOU and/or YOUR FAMILY** on either your **mother's or father's side**. After each statement, please list the diagnosed individual's relationship to you (**For Example, self, mother, father, sisters/brothers, grandparents, aunts, uncles, cousins, nieces/nephews** and the **age at diagnosis**. This is a screening tool for common features of hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

Have YOU or ANYONE in your family been tested for a Hereditary Cancer Syndrome? Yes / No
Which & When? _____

DIAGNOSIS			**FAMILY MEMBER**	**AGE OF ONSET**
BREAST AND OVARIAN CANCER:				
Y	N	- Breast cancer	_____	_____
Y	N	- Ovarian cancer	_____	_____
Y	N	- Breast cancer in both breasts or in the same breast twice	_____	_____
Y	N	- Both breast & ovarian cancer (in an individual)	_____	_____
Y	N	- Male breast cancer	_____	_____
Y	N	- Ashkenazi Jewish ancestry	_____	_____
COLON AND UTERINE CANCER:				
Y	N	- Uterine cancer	_____	_____
Y	N	- Colorectal cancer	_____	_____
Y	N	- Both uterine & colorectal cancer (in an individual)	_____	_____
Y	N	- Stomach/small bowel		
Y	N	- Kidney/urinary tract or brain (in an individual)	_____	_____
Y	N	- 10 or more colon polyps found in a lifetime	_____	_____
OTHER CANCER:				
Y	N	- Melanoma	_____	_____
Y	N	-Pancreatic	_____	_____
Y	N	_____	_____	_____
Y	N	_____	_____	_____