

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Gender (M/F): _____ Today's Date (MM/DD/YY): _____ Health Care Provider: _____

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, 1st cousins, great-grandparents and great-grandchildren.

Cancer	You: Age of Dx	Siblings/ Children	Age of Dx	Mother's Side	Age of Dx	Father's Side	Age of Dx
EXAMPLE: 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 Cancer (uterine)							
Colon/Rectal Cancer							
20 or more Lifetime Colon Polyps (specify #)							
Pancreatic Cancer							
Prostate Cancer							
Other Cancers (specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

Are you of Ashkenazi Jewish descent? Yes No

Are you concerned about your personal and/or family history of cancer? Yes No

BREAST CANCER RISK MODEL INFORMATION

Your current height (ft/in) _____

Your current weight (lbs) _____

Your menopausal status:

- Pre-menopausal
- Peri-menopausal
(time before menopause marked by irregular cycles)
- Post-menopausal
(permanent cessation of period for 12 months or longer)
- Age of onset _____

Your age at time of first menstrual period _____

Have you had a live birth? No Yes:

Age at time of first live birth: _____

Did you ever use Hormone Replacement Therapy? Yes No

If yes, type: Combined Estrogen only Progesterone only Don't know

If yes, are you a: Current user: How many years ago did you start? _____
How many more years do you intend to use? _____

Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? Yes No

If yes, do you know your diagnosis? _____

Number of daughters _____

Number of sisters _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Office Use Only	Patient offered hereditary cancer genetic testing? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ACCEPTED <input type="checkbox"/> DECLINED
	If yes and accepted, which test? <input type="checkbox"/> BRACAnalysis* with Myriad myRisk* <input type="checkbox"/> Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk* <input type="checkbox"/> COLARIS ^{PLUS} with Myriad myRisk* <input type="checkbox"/> COLARIS AP ^{PLUS} with Myriad myRisk* <input type="checkbox"/> Single Site Testing <input type="checkbox"/> Myriad myRisk* Update
	Other: _____
	Follow-up appointment scheduled: <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Next Appointment: _____

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HEREDITARY CANCER RED FLAGS (To be completed with your healthcare provider - Check all that apply)

<input type="checkbox"/> Breast cancer at or before age 45	Integrated BRACAnalysis* with Myriad myRisk*	<input type="checkbox"/> 20 or more lifetime colon/rectal polyps found in 1 person. Specify number _____	COLARIS-AP ^{PLUS}
<input type="checkbox"/> 2 or more separate breast cancers in one person, one at age 50 or younger		<input type="checkbox"/> Colon/rectal or endometrial (uterine) cancer before age 50	COLARIS ^{PLUS} with Myriad myRisk*
<input type="checkbox"/> 2 or more people in my family (can include me) with breast cancer, one at age 50 or younger		<input type="checkbox"/> Personal history of endometrial (uterine) cancer at any age*	
<input type="checkbox"/> Ovarian (peritoneal/fallopian tube) cancer at any age		<input type="checkbox"/> 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="checkbox"/> Triple negative breast cancer at age 60 or younger (ER-, PR-, HER2-Pathology)		<input type="checkbox"/> 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="checkbox"/> Three or more of these cancers on same side of the family at any age: pancreatic, breast, or aggressive prostate*		<input type="checkbox"/> Have you or a family member had genetic testing for a hereditary cancer syndrome? If yes, Who? _____ What gene? _____ What was the result? _____	Single Site Testing
<input type="checkbox"/> Male breast cancer at any age			
<input type="checkbox"/> Pancreatic cancer or aggressive prostate cancer* and one relative with breast cancer at age 50 or younger *Gleason Score ≥ 7			
<input type="checkbox"/> Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age	Multisite3 BRAC-Analysis*		