# Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________________ Physician: ______________________________

Date Completed: ____________________

Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age at diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

| | YOU | SIBLINGS/ | MOTHER'S SIDE | FATHER'S SIDE |
|---|---|---|---|---|
| *For example:*<br>**Colorectal cancer** | | **Brother 36 yrs** | **Aunt 44 yrs**<br>**Cousin 58 yrs** | **Grandfather 65 yrs** |
| **BREAST AND OVARIAN CANCER** | | | | |
| **Breast cancer** | | | | |
| **Ovarian cancer** | | | | |
| **Breast cancer in both breasts OR multiple primary breasts** | | | | |
| **Male breast cancer** | | | | |
| **Are you of Ashkenazi Jewish descent?** | | | | |
| **COLON AND UTERINE CANCER** | | | | |
| **Uterine (endometrial) cancer** | | | | |
| **Colorectal cancer** | | | | |
| **Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer** | | | | |
| **10 or more colon polyps** | | | | |
| **MELANOMA** | | | | |
| **Melanoma** | | | | |
| **Pancreatic cancer** | | | | |
| **OTHER CANCER** | | | | |
| ____________________ | | | | |

| FOR OFFICE USE ONLY | |
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| ❑Patient appropriate further risk assessment and/or genetic testing<br>❑ BRAC*Analysis*® - A test for Hereditary Breast and Ovarian Cancer<br>❑ COLARIS® - A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)<br>❑ COLARIS *AP*® - A test for Hereditary Breast and Ovarian Cancer<br>❑ MELARIS® - A test for Hereditary Breast and Ovarian Cancer | ❑ Patient given information to review<br>❑ Patient offered genetic testing<br>❑ACCEPTED ❑DECLINED<br>❑Follow up appointment scheduled<br>Date: |