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 __________

Your 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: __________

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

	Test		Test
☐ **Breast cancer** at or before age 45	IntegratedBRACAnalysis withMyriadmyRisk	☐ 20 or more lifetime colon/rectal polyps found in 1 person. Specify number_______	COLARIS-AP PLUS
☐ 2 or more separate **breast cancers** in one person, one at age 50 or younger		☐ **Colon/rectal** or **endometrial** (uterine) **cancer** before age 50	COLARIS PLUS withMyriadmyRisk
☐ 2 or more people in my family (can include me) with **breast cancer**, one at age 50 or younger		☐ Personal history of **endometrial(uterine) cancer** at any age	
☐ **Ovarian (peritoneal/fallopian tube) cancer** at any age		☐ 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	
☐ **Triple negative breast cancer** at age 60 or younger (ER-, PR-, HER2-Pathology)			
☐ Three or more of these cancers on same side of the family at any age: **pancreatic, breast**, or **aggressive prostate***		☐ 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 PREMM Score ≥ 5% * Lynch-associated cancers include: colon, endometrial (uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).	
☐ Male **breast cancer** at any age			
☐ **Pancreatic cancer or aggressive prostate cancer*** and one relative with **breast cancer at age 50 or younger** *Gleason Score ≥ 7		☐ 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
☐ Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	Multisite3 BRACAnalysis		

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Patient offered hereditary cancer genetic testing? ☐YES ☐NO ACCEPTED ☐ DECLINED

If yes and accepted, which test? BRAC*Analysis* with Myriad myRisk Multisite 3 ☐ BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

☐ COLARIS PLUS with Myriad myRisk COLARIS *AP* PLUS with Myriad myRisk Single Site Testing ☐Myriad myRisk Update Other:

☐ ______________________

Follow-up appointment scheduled: YES NO Date of Next Appointment: ______________

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