CANCER FAMILY HISTORY QUESTIONNAIRE

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

Gender (M/F):_____ Today's Date(MM/DD/YY):_____ Doctor You're Seeing Today:_____

Instructions: This is a screening tool for cancers that run in families. Please circle (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered:

You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

1 YOU			2 YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)					
	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
X Y N	EXAMPLE BREAST CANCER	45	—	—	Aunt Cousin	45 61	Grandmother	53
Y N	BREAST CANCER							
Y N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
Y N	UTERINE/ENDOMETRIAL CANCER							
Y N	COLON/RECTAL CANCER							
Y N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
Y N	OTHER CANCER(S) ***Circle Cancer Below***							
	Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Prostate							

Y N Are you of Ashkenazi Jewish descent?

Y N Are you concerned about your personal and/or family history of cancer?

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

FOR OFFICE USE ONLY

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only: Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

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

Hereditary Cancer Red Flags (to be completed by your health care provider)

Personal **and/or** family history of any one of the following:

☐	**Young** Any 1 of the following at age **50 or younger**:	o Breast cancer o Colorectal cancer o Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **Any age:**	o Ovarian cancer o Breast: Male breast cancer o Triple negative breast cancer o o 10 or more **cumulative** precancerous gastrointestinal polyps*
☐	**Multiple** **3rd degree...Need 3 or more** A combination of cancers on the same side of the family:	o **3 or more**: breast / ovarian / prostate / pancreatic cancer o **3 or more**: colorectal / endometrial/ovarian/gastric/pancreatic/oth (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) melanoma / pancreatic

++Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/ signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com