Cancer Risk Assessment Questionnaire

Patient Name: _____ Physician Name: _____ Today's Date: _____

Patient Date of Birth: _____ Age: ____ Age at first period: ____ Age at first live birth: _____

Instructions: Your physician **NEEDS** this information to perform an accurate assessment of your medical & cancer risks. Answer the questions by circling *YES or NO. If you circle YES, provide the relationship of the family member with the illness/cancer **and** their **age** at diagnosis.* Please consider the following relatives:

Mother/Father/Sisters/Brothers/Children (**1st degree relatives**),
Aunts/Uncles/Grandparents/Nieces/Nephews (**2nd degree relatives**),
Cousins/Great-Grandparents (**3rd degree relatives**)

QUESTIONS			SELF Age of Diagnosis	RELATIVES on MOTHER'S SIDE (Include Age of Diagnosis)	RELATIVES on FATHER'S SIDE (Include Age of Diagnosis))
***EXAMPLE:** Have you or any relatives been diagnosed with breast cancer under age 50?*	(YES)	NO	55	Mother, 45	Grandmother, 60 Aunt, 75
Have you or any relatives been diagnosed with breast cancer **under age 50**?	YES	NO			
Have you or any relatives been diagnosed with ovarian cancer at any age?	YES	NO			
Do you have **2** or more breast cancers in the same person or on the same side of family, one at age 50 or younger?	YES	NO			
3 or more of **any** of these cancers at any age, on same side of family: breast, pancreatic or prostate cancer?	YES	NO			
Male breast cancer at any age?	YES	NO			
Jewish ancestry, with breast cancer any age?	YES	NO			
You or any relative with colon **or** uterine (endometrial) cancer **under age 50**?	YES	NO			
2 relatives, on same side of family, with colon **or** uterine cancer, one at age 50 or younger?	YES	NO			
Do you have **3 or more** relatives, at any age, diagnosed with the following cancers: colon, uterine (endometrial), ovarian, pancreatic, bowel, (please list who & ages)	YES	NO			

Have you or a family member had genetic testing for a BRCA or Lynch mutation? (myRisk test) YES / NO If yes, who: _____

Patient Signature: _____ **Date:** _____

Healthcare Provider Signature: _____ **Date:** _____

Meets testing criteria: ☐ **Yes** ☐ **No** ☐ **Recommended genetic testing:** ☐ **Accepted** ☐ **Declined**