CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name:_____ **MD/PA/NP** You are Seeing Today:_____

Date of Birth:_____ Age:_____ Today's Date:_____

Have **you or any relatives** been tested for hereditary cancer (BRCA) in the past? YES NO Who?_____Results:_____Year_____

Do you have any Ashkenazi Jewish ancestry? NO Mother's Side of Family Father's Side of Family BOTH

Have **YOU** ever been diagnosed with **any type of cancer**? YES NO Cancer site:_____ Age at diagnosis:_____

INSTRUCTIONS: Your family history is important. This is a screening questionnaire for the common features of hereditary cancers.
For the sake of this questionnaire, **CLOSE RELATIVE** is defined as a 1st or 2nd degree relative:
1st degree: Mother, Father, Sister, Brother, Children **2nd degree:** Aunt, Uncle, Grandparent, Niece, Nephew

		Breast and Ovarian Cancer Family History	Mother's Side of Family	Age at Diagnosis	Father's Side of Family	Age at Diagnosis
(Y)	N	**EXAMPLE:** Do you have a close relative diagnosed with breast cancer before age 45?	**Sister - Ovarian**	**60**	**Aunt - Breast**	**41**
Y	N	Do you have a close relative diagnosed with **BREAST** cancer at **AGE 45 OR YOUNGER**?				
Y	N	Do you have a close relative diagnosed with **OVARIAN** cancer **AT ANY AGE**?				
Y	N	Do you have **TWO** close relatives on the **same side of the family** diagnosed with breast cancer, **one at AGE 50 OR YOUNGER**?	1.		1.	
			2.		2.	
Y	N	Do you have **THREE relatives** on the same side of the family diagnosed with **BREAST** cancer **at any age**?	1.		1.	
			2.		2.	
			3.		3.	
Y	N	Do you have a close relative diagnosed with **multiple breast cancers** in the same or both breasts?				
Y	N	Do you have a close **MALE RELATIVE** diagnosed with breast cancer?				
Y	N	Are you of Ashkenazi Jewish ancestry **AND** have any family members with breast, ovarian or pancreatic cancer **at any age**?				
Y	N	Is there a **pancreatic** cancer on the **same side** of the family as a breast or ovarian cancer?				
Y	N	Do you have a close relative with a known BRCA or other genetic mutation?				
Y	N	Has anyone in your family been diagnosed with a "triple negative" breast cancer?				

		Colon and Endometrial (Uterine) Cancer Family History	Mother's Side of Family	Age at Diagnosis	Father's Side of Family	Age at Diagnosis
Y	N	Do you have **TWO close relatives** on the same side of the family diagnosed with colon, endometrial (uterine), or ovarian cancer, **one at AGE 50 OR YOUNGER**?	1.		1.	
			2.		2.	
Y	N	Do you have **THREE relatives** on the same side of the family diagnosed with colon, endometrial (uterine), or ovarian cancer at any age?	1.		1.	
			2.		2.	
			3.		3.	
Y	N	Do you have a close relative with a known Lynch Syndrome mutation?				

List ANY OTHER CANCER in your family below. Also include any 3rd DEGREE RELATIVES HERE: COUSINS, GREAT GRANDPARENTS, GREAT AUNTS/UNCLES

_____

_____

OFFICE USE:

Patient is appropriate for further risk assessment and/or genetic testing: **YES / NO / PT already Tested**

◯**PATIENT DECLINED TESTING**, Pt acknowledged understanding of increased risk due to family history of cancers noted above but declines testing today. Pt advised to RTO if desires testing in the future.

◯**PATIENT ACCEPTED TESTING**, Informed consent obtained. Bloodwork drawn today.
Follow up appt in 4-6 weeks to review results and for risk reduction counseling.

PATIENT Signature: _____

HCP Signature: _____