

**We are committed to your health  
and cancer prevention.**

**To best serve you, we need a detailed  
personal and family cancer history.  
Please fill out the back of this form.  
If you have questions please ask!**

If you filled this out within the last 6 months and nothing has changed, you do not need to fill it out again. Just SIGN it and indicate as such on the form.

**THANK YOU!**

*\*If you have already had genetic testing for a hereditary cancer syndrome (BRCA) and your family history has not changed, you do not need to complete this form\**

## Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Has anyone in your family had genetic testing for a hereditary cancer syndrome?**

**(Ex: BRCA or Lynch)? Yes or No**

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

### BREAST AND OVARIAN CANCER (BRCA)

			You (age at diagnosis)	Siblings / Children (age at diagnosis) <i>Ex: Brother 36 yrs</i>	Mother's Side (Who + age at diagnosis) <i>Ex: Aunt 44 yrs</i>	Father's Side (Who + age at diagnosis)
Y	N	Breast cancer (please note if it was triple neg)				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian/fallopian tube cancer				
Y	N	Male breast cancer				
Y	N	Are you of Jewish descent?				

### COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, biliary tract, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

### OTHER CANCERS

Y	N	Prostate Cancer (BRCA)				
Y	N	Pancreatic Cancer (Col/BRCA)				
Y	N	Melanoma				

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### For Office Use Only:

BRCA/Lynch Testing Indicated?: YES NO  
 Patient offered hereditary cancer testing? YES NO If YES: ACCEPTED DECLINED  
 Follow-up appointment scheduled: YES NO Date of Appointment: \_\_\_\_\_

<p><b>BRCA – Personal or Fam. History</b></p> <p>One person with (out to 2<sup>nd</sup> degree)</p> <ul style="list-style-type: none"> <li>• Breast Cancer at 49 or younger</li> <li>• Ovarian Cancer at any age</li> <li>• Male breast cancer any age</li> <li>• Pancreatic cancer any age</li> <li>• Bilateral Breast at any age</li> <li>• Triple Neg Br.Ca. at 60 or younger</li> <li>• Jewish ancestry w/ovarian, pancreatic or breast cancer any age</li> </ul>	<p><b>BRCA – Personal or Fam. History</b></p> <p>Two persons with (out to 3<sup>rd</sup> Degree)</p> <ul style="list-style-type: none"> <li>• 2 Breast Cancers, w 1 ≤ 50 or younger</li> </ul> <p>Three Persons with (out to 3<sup>rd</sup> degree)</p> <ul style="list-style-type: none"> <li>• Breast and/or Ovarian and/or Pancreatic (any age)/aggressive Prostate</li> </ul>	<p><b>Lynch Syndrome (Colon/Endo)</b></p> <p>Personally affected with:</p> <ul style="list-style-type: none"> <li>• Colon or Endometrial at ≤ 64</li> </ul> <p>Family History out to 2<sup>nd</sup> Degree:</p> <ul style="list-style-type: none"> <li>• 1 Colon or Endometrial Cancer ≤ 49</li> <li>• 10+ Colon polyps found in a lifetime</li> <li>• 2 or more Lynch* cancers in the same person</li> <li>• 2 or more Lynch* cancers w/1 dx ≤ 50</li> </ul> <p>*(gastric, ovarian, brain, kidney, small bowel, pancreas, ureter, biliary tract)</p>
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MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_

