Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: Physician:						
Da	te o	t Name: Ph f Birth: Da	ate completed:			
inc	livid	ctions: Please circle \underline{Y} to those that apply to \underline{YOU} and/or lual diagnosed (such as Self, Uncle, Aunt, Grandmother) itary Cancer Syndromes, if you circle \underline{Y} to any statement	& their age at diagnosis.	This is a scre	ening tool	for
BREAST & OVARIAN CANCER (BRCA)			Relationship	Mother's Side	Father's Side	Age Diagnosed
Y	N	- Breast Cancer before age 50		Y	Y	
Y	N	- Ovarian Cancer at any age		Y	Y	
Y	N	- Breast Cancer in both breasts or multiple primary Breast Cancers		Y	Y	
Y	N	- Both Breast & Ovarian Cancer (in an individual or family)		Y	Y	
Y	N	- Male Breast Cancer		Y	Y	
Y	N	- 2 or more Breast or Ovarian Cancers (in an individual or a family)		Y	Y	
Y	N	- Pancreatic Cancer w/ family history of Breast or Ovarian		Y	Y	
Y	N	- Ashkenazi Jewish ancestry & personal or family history of Breast or Ovarian Cancer		Y	Y	
Y	N	- Are you of Jewish descent?		Y	Y	
Y	N	- Patient has Breast Cancer diagnosed after age 50 & has 1 relative with Breast Cancer		Y	Y	
Y	N	- Any unaffected patient with 3 relatives with Breast Cancer, regardless of age		Y	Y	
Y	N	- Triple Negative Breast Cancer		Y	Y	
Y	N	- Family member with known BRCA Mutation		Y	Y	
COLON & UTERINE CANCER (COLARIS)			Relationship	Mother's Side	Father's Side	Age Diagnosed
Y	N	- Uterine Cancer before age 50		Y	Y	
Y	N	- Colorectal Cancer before age 50		Y	Y	
Y	N	- Both Uterine & Colorectal Cancer (in an individual or family)		Y	Y	
Y	N	 2 or more Uterine or Colorectal Cancers (in an individual or family) 		Y	Y	
Y	N	 Uterine and/or Colorectal Cancer AND Ovarian, Stomach, Kidney/Urinary Tract, Brain OR Small Bowel Cancer (in an individual or family) 		Y	Y	
COLON & UTERINE CANCER (COLARIS AP)			Relationship	Mother's Side	Father's Side	Age Diagnosed
Y	N	- 10 or more Colon Polyps found in a lifetime (in an individual or a family)		Y	Y	
☐ Information given to patient to review ☐ Patient offered genetic testing: ☐ Accepted ☐ Declined ☐ Candidate for further risk assessment and/or genetic testing ☐ Follow up appointment scheduled						
_X						

Health Care Provider's Signature

Date

Patient's Signature

Date