Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ___________________________  Physician: ___________________________

Date Completed: _______________________

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

<table>
<thead>
<tr>
<th>YOU</th>
<th>SIBLINGS/CHILDREN</th>
<th>MOTHER’S SIDE</th>
<th>FATHER’S SIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For example:</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Colorectal cancer</td>
<td>Brother 30 yrs</td>
<td>Aunt 44 yrs</td>
<td>Grandfather 65 yrs</td>
</tr>
</tbody>
</table>

**BREAST AND OVARIAN CANCER**
- Breast cancer
- Ovarian cancer
- Breast cancer in both breasts OR Multiple primary breast cancers
- Male breast cancer
- Are you of Ashkenazi Jewish descent?

**COLON AND UTERINE CANCER**
- Uterine (endometrial) cancer
- Colorectal cancer
- Ovarian, stomach, kidney/urinary tract, brain, OR small bowel cancer
- 10 or more cumulative colon polyps

**MELANOMA**
- Melanoma
- Pancreatic cancer

**OTHER CANCER**

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**FOR OFFICE USE ONLY**

- Patient appropriate for further risk assessment and/or genetic testing
- BRACAnalysis® – A test for Hereditary Breast and Ovarian Cancer
- COLARIS® – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)
- COLARIS AP® – A test for Adenomatous Polyposis Syndromes
- MELARIS® – A test for Hereditary Melanoma
- Discussed hereditary cancer risk with patient
- Patient offered genetic testing
  - ACCEPTED  □  DECLINED  □
- Follow up appointment scheduled
  Date:___________