HEREDITARY CANCER SCREENING

Family History Questionnaire

Please help your healthcare provider by completing the following Questionnaire. Your information will allow them to evaluate and possibly lower YOUR risk of developing Hereditary Cancer that may run in your family.

	Colon and Uterine Cancer	You	Mother's Side	Father's Side	Age at Diagnosis
Y N	Uterine cancer before age 50				
Y N	Colorectal cancer before age 50				
Y N	Both Uterine and Colorectal cancer (in an individual or family)				
Y N	Two or more Uterine or Colorectal cancers (in an individual or family)				
Y N	Ovarian cancer (in an individual or family)				
Y N	Stomach, Kidney/Urinary Tract, Brain OR Small Bowel cancers (in an individual or family)				
Y N	Ten or more Colon polyps found in a lifetime				
	Breast and Ovarian Cancer	**You**	**Mother's Side**	**Father's Side**	**Age at Diagnosis**
Y N	Breast cancer before age 50				
Y N	Ovarian cancer				
Y N	Breast cancer in both breast or multiple primary breast cancers				
Y N	Both Breast and Ovarian cancer (in an individual or family)				
Y N	Male breast cancer				
Y N	Two or more breast or ovarian cancers (in an individual or family)				
Y N	Ashkenazi Jewish ancestry and personal or family history of breast or ovarian cancer				

Yes	No	
☐	☐	Candidate for further risk assessment and/or genetic testing
☐	☐	Information given to patient for review
☐	☐	Follow-up appointment scheduled

Date: _____

Patient offered genetic testing?

☐ Accepted ☐ Declined

_____

Patient's Signature Date

_____

Health Care Professional's Signature Date