Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth:_____

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.

. *Example: Colon Cancer* *Brother 36 yrs* *Aunt 44 yrs* *Grandfather 65 yrs* *Cousin 58 yrs*

BREAST AND OVARIAN CANCER

			You	Siblings / Children	**Mother's Side**	**Father's Side**
Y	N	Breast cancer				
Y	N	Ovarian cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Male breast cancer				
Y	N	Are you of Ashkenazi Jewish descent?				

COLON AND UTERINE CANCER

			You	Siblings / Children	**Mother's Side**	**Father's Side**
Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer				
Y	N	10 or more colon polyps found in a lifetime				

MELANOMA:

			You	Siblings / Children	**Mother's Side**	**Father's Side**
Y	N	Melanoma				
Y	N	Pancreatic Cancer				

OTHER CANCERS

		Type of cancer	You	Siblings / Children	**Mother's Side**	**Father's Side**
Y	N					

For Office Use Only:

☐ Patient offered genetic testing: ☐ ACCEPTED ☐ DECLINED

Patient's Signature:_____ Date: _____

Health Care Provider's Signature: _____ Date: _____