

# CANCER FAMILY HISTORY QUESTIONNAIRE

## Personal Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Gender (M/F): \_\_\_\_\_ Today's Date (MM/DD/YY): \_\_\_\_\_ Health Care Provider: \_\_\_\_\_

**Instructions:** This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

**You and the following close blood relatives should be considered:** You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents and Great Grandchildren

## YOU and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	CANCER	YOU AGE OF Diagnosis	PARENTS / SIBLINGS / CHILDREN	AGE OF Diagnosis	RELATIVES on your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE: BREAST CANCER	45	-----	--	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE/ENDOMETRIAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME COLON POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OTHER CANCER(S) (Specify cancer type)	Among others, consider the following cancers: Melanoma, Pancreatic, Stomach/Gastric, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

Y  N Are you of Ashkenazi Jewish descent?

Y  N Are you concerned about your personal and/or family history of cancer?

Y  N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? (Please explain/include a copy of result if possible)

## Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

### Your PERSONAL History - Red Flags

#### Hereditary Breast and Ovarian Cancer Syndrome

- Breast cancer diagnosed at age 50 or younger
- Ovarian cancer at any age
- Two primary occurrences of breast cancer
- Male breast cancer
- Triple Negative Breast Cancer
- Pancreatic cancer with a breast or ovarian cancer
- Ashkenazi Jewish ancestry with an HBOC-associated cancer\*

#### Lynch Syndrome\*\* (see cancer list below)

- Colorectal cancer under age 50
- Endometrial/uterine cancer under age 50
- MSI High histology\*\*\* before age 60
- Abnormal MSI/IHC tumor test result (colon/rectal/endometrial/uterine)
- Two or more Lynch syndrome cancers\*\* at any age
- YOU and one or more relatives with a Lynch syndrome cancer\*\*

\*HBOC associated cancer includes: Breast, ovarian, and pancreatic cancer

\*\*Lynch syndrome cancer includes: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas

\*\*\*MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, crahn's-like lymphocytic reaction histology, or medullary growth pattern

### Your FAMILY History - Red Flags

#### Hereditary Breast and Ovarian Cancer Syndrome

- Close relative with breast cancer less than age 50
- Close relative with ovarian cancer at any age
- Two or more breast cancer occurrences, in one relative or in two or more relatives on the same side of the family, one under age 50
- A male relative with breast cancer
- Combination of breast, ovarian, and/or pancreatic cancer on the same side of the family.

- Three or more relatives with breast cancer at any age

- A previously identified BRCA1 or BRCA2 mutation in the family

#### Lynch Syndrome\*\* (see cancer list below)

- Two or more relatives with a Lynch syndrome cancer\*\*, one before the age of 50
- Three or more relatives with a Lynch syndrome cancer\*\* at any age
- A previously identified Lynch syndrome mutation in the family

## Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

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

Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only: Patient offered hereditary cancer genetic testing?  YES  NO  ACCEPTED  DECLINED

Follow-up appointment scheduled:  YES  NO Date of Next Appointment: \_\_\_\_\_