

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Height: _____ **Weight:** _____ **Age of First Period:** _____ **Age at birth of First Child (If Applicable):** _____

Are you Menopausal? Y (at age _____) or N **Have you ever used Hormone Replacement Therapy?** Y or N

Has anyone in your family had genetic testing for a hereditary cancer syndrome (Ex: BRCA or Lynch)? Y / N

Please mark below if there is a personal or family history of any of the following cancers.

Indicate family relationship and **AGE at diagnosis** in the appropriate column.

Consider: parents, children, brothers, sisters, grandparents, great grandparents, aunts, uncles, and cousins.

BREAST AND OVARIAN CANCER (BRCA)			You (age at diagnosis)	Siblings / Children (Who + age at diagnosis) <i>Ex: Brother, 36 yrs</i>	Mother's Side (Who + age at diagnosis) <i>Ex: Aunt, 44 yrs</i>	Father's Side (Who + age at diagnosis) <i>Ex: Grandfather, 65</i>
Y	N	Breast cancer				
Y	N	Breast cancer in both breasts OR multiple primary breast cancers				
Y	N	Ovarian cancer (includes fallopian tube & peritoneal)				
Y	N	Pancreatic cancer				
Y	N	Male breast cancer				
Y	N	Prostate Cancer (indicate if metastatic or not)				
Are you of Ashkenazi Jewish descent? Y N						

COLON AND UTERINE CANCER (Colaris)

Y	N	Uterine (endometrial) cancer				
Y	N	Colon cancer				
Y	N	Ovarian, stomach, brain, kidney/urinary tract OR small bowel cancer (circle any applicable)				
Y	N	10 or more colon polyps found in a lifetime				

OTHER CANCERS

Y	N	Melanoma				
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Patient's Signature (required): _____ **Date:** _____

For Office Use Only: BRCA/Lynch testing indicated? YES NO

Follow-up appointment scheduled: YES or NO

Patient offered hereditary cancer testing? YES or NO If YES: ACCEPTED DECLINED Appointment Date _____

<p>BRCA - Personal or Family History</p> <ul style="list-style-type: none"> • Known mutation at any age, any degree of relation <p>One person (out to 2nd degree) with:</p> <ul style="list-style-type: none"> • Breast cancer at age 49 or younger • Ovarian cancer at any age • Male breast cancer at any age • Metastatic prostate cancer any age • Pancreatic cancer at any age • Breast cancer + Jewish heritage • Bilateral breast cancer at any age • Triple negative breast cancer at age 60 or younger • Ashkenazi Jewish heritage w/ breast or high-grade (Gleason 7+) prostate cancer at any age 	<p>BRCA - Personal or Family History Two persons (out to 3rd degree) with:</p> <ul style="list-style-type: none"> • 2 Breast cancers. w/ one dx at age 50 or younger, the other any at age • 1 Breast. plus one ovarian QI pancreatic QI metastatic prostate at any age • 1 Breast at age 50 or younger. plus one high-grade prostate at any age • 1 high-grade prostate cancer. plus ovarian cancer QI pancreatic cancer QI metastatic prostate cancer at any age <p>Three persons (out to 3rd degree) with:</p> <ul style="list-style-type: none"> • Breast and/or Ovarian and/or Pancreatic at any age/aggressive or early Prostate cancer 	<p>Lynch Syndrome (Colon/Endo)</p> <ul style="list-style-type: none"> • Known mutation at any age, any degree of relation <p>Personally affected with:</p> <ul style="list-style-type: none"> • Colon <u>or</u> Endometrial at age 49 or younger • Colon <u>or</u> Endometrial. plus one other Lynch dx at any age • Colon <u>or</u> Endometrial at any age, plus one 1st/2nd degree relative with a Lynch dx at age 50 or younger • Colon <u>or</u> Endometrial. plus two 1st/ 2nd degree relatives with a Lynch dx at any age <p>Family History (1st degree only):</p> <ul style="list-style-type: none"> • Colon <u>or</u> Endometrial at age 49 or younger • Colon <u>or</u> Endometrial plus one other Lynch dx in same person at any age <p>Family History (1st & 2^o degree only):</p> <ul style="list-style-type: none"> • 2 or more persons dx with Lynch* cancers. at least one dx at age 49 or younger • 3 or more persons dx with Lynch* cancers at any age <p>*colon,endometrial gastric,ovarian,brain. Kidney,small bowel, pancreatic, ureter,biliary tract</p>
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MD Signature: _____ **Date:** _____