# 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 <u>age at diagnosis</u> 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					
			1			

□ Patient offered genetic testing: □ ACCEPTED □ DECLINED

Patient's Signature:

Date:

Health Care Provider's Signature:

Date: