Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Date of Birth: _____

Your height (ft/in): _____ Your age at time of first menstrual period: _____

Your weight (lbs): _____ Your age at time of first live birth: _____

Your menopausal status (circle one):

Pre-menopausal Peri-menopausal Post menopausal - age of onset: _____

Did you ever use Hormone Replacement Therapy? Yes No

If yes, type: Combined Estrogen Only Progesterone Only

If yes, are you a: Current user: How many years ago did you start? _____

How many more years will you use? _____

Past User: How many years ago did you stop?_____

Have you ever had a breast biopsy? Yes No

If yes, do you know your diagnosis? _____

Number of daughters: _____ Number of sisters: _____

Number of maternal aunts: _____ Number of paternal aunts: _____

Has anyone in your family had genetic testing for a hereditary cancer syndrome? Yes No

Have you or a close relative (parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews) had any of the following:

- ▢ Breast cancer at age of 50 or younger
- ▢ Ovarian cancer at any age
- ▢ Male breast cancer at any age
- ▢ Pancreatic Cancer at any age
- ▢ Metastatic prostate cancer at any age
- ▢ Uterine cancer at age 49 or younger
- ▢ Triple negative breast cancer at any age
- ▢ Two different breast cancers in one relative at any age
- ▢ Three breast cancers in relatives on the same side of the family
- ▢ Ashkenazi Jewish Ancestry
- ▢ Colon cancer at age 49 or younger
- ▢ Three colon and/or uterine cancers on the same side of the family

If you checked any of the boxes please complete the chart below:

Cancer Type	Person (yourself or blood relative)	Age	Mother's Side	Father's Side	Relative deceased
EXAMPLE: *Breast Cancer*	*Aunt*	*40s*	*X*		*No*