Family History Questionnaire for Common Hereditary Cancer Syndromes

VALLEY WOMENS HEALTHCARE MEDICAL GROUP

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Name: _____ **DOB:** _____ **Age:** _____

Fill in Each Section Below

	Height
	Weight
	Age of First Period
	Age you delivered your first child (if applicable)
	Age of your mother
	Are you Menopausal

Best Contact Phone Number(s): _____

Email: _____

Yes	No	
		Have you ever used hormone replacement therapy? If yes, how long?
		Has anyone in your family had genetic testing for hereditary cancer syndrome (Ex: BRCA or LYNCH)? If Yes, what was the result?

Please mark **Yes or No** in the boxes below next to each **Personal or Family History** of any of the following cancer and **Indicate Family Relationship** and **Their Age at Diagnosis** in the appropriate column. Consider parents, children, siblings, grandparents, aunts, uncles, and cousins.

Yes	No	Symptom	You (age at diagnosis)	Siblings/Children (Who + age at diagnosis) Ex: Brother, 36 yrs	Your Mother's Side (Who + age at diagnosis) Ex: Aunt, 44 yrs	Your Fathers's Side (Who + age at diagnosis) Ex: Grandpa, 65 yrs
		Breast Cancer				
		Breast Cancer in both breasts OR multiple primary breast cancers				
		Ovarian Cancer				
		Male Breast Cancer				
		Are you of Ashkenazi Jewish Descent?				
		Uterine (Endometrial) Cancer *(Note: Do not include cervical cancer)*				
		Colon Cancer				
		Stomach, Kidney/Urinary tract, brain, or small bowel/intestinal cancer *(NOTE: Please circle or write appropriate cancer in column)*				
		10 or more colon polyps found in a lifetime				
		Prostate Cancer				
		Pancreatic Cancer (Col/BRCA)				
		Malignant Melanoma				
		Other Cancers				

For Office Use Only

Yes	No	
		Patient offered hereditary cancer testing? If yes, **did the patient Accept or Decline:** _____
		Follow- Up Appointment Scheduled If Yes, **Date of Appointment:** _____

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

Personal and/or family history of any one of the following:

☐	**Multiple** A combination of cancers on the same side of the family:	○ **2 or more**: breast / ovarian / prostate / pancreatic cancer ○ **2 or more**: colorectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) ○ **2 or more**: melanoma / pancreatic
☐	**Young** Any 1 of the following at age **50 or younger**:	○ Breast cancer ○ Colorectal cancer ○ Endometrial cancer
☐	**Rare** Any 1 of these rare presentations at **any age**:	○ Ovarian cancer ○ Breast: Male breast cancer or Triple negative breast cancer ○ Colorectal cancer with abnormal MSI/IHC, or MSI associated histology†† ○ Endometrial cancer with abnormal MSI/IHC ○ 10 or more colorectal polyps*

††Presence of tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern *Adenomatous type

Assessment criteria are based on medical society guidelines. For individual medical society guidelines, go to www.MyriadPro.com

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

Patient/Responsible Party Signature **Date** **Clinician/Physician Signature of Review** **Date**