

**Family History Questionnaire for
Common Hereditary Cancer Syndromes**

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Name: _____ DOB: _____ Age: _____

Fill in Each Section Below

<input type="checkbox"/>	Height	Best Contact	
<input type="checkbox"/>	Weight	Phone Number(s):	_____
<input type="checkbox"/>	Age of First Period		
<input type="checkbox"/>	Age you delivered your first child (if applicable)		_____
<input type="checkbox"/>	Age of your mother		
<input type="checkbox"/>	Are you Menopausal	Email:	_____
<input type="checkbox"/>	Yes	No	
<input type="checkbox"/>	Have you ever used hormone replacement therapy? If yes, how long?		_____
<input type="checkbox"/>	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 Father's Side (Who + age at diagnosis) Ex: Grandpa, 65 yrs
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer in both breasts OR multiple primary breast cancers				
<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	Male Breast Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	Are you of Ashkenazi Jewish Descent?				
<input type="checkbox"/>	<input type="checkbox"/>	Uterine (Endometrial) Cancer <i>(Note: Do not include cervical cancer)</i>				
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, Kidney/Urinary tract, brain, or small bowel/intestinal cancer <i>(NOTE: Please circle or write appropriate cancer in column)</i>				
<input type="checkbox"/>	<input type="checkbox"/>	10 or more colon polyps found in a lifetime				
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Cancer				
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Cancer (Col/BRCA)				
<input type="checkbox"/>	<input type="checkbox"/>	Malignant Melanoma				
<input type="checkbox"/>	<input type="checkbox"/>	Other Cancers				

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<input type="checkbox"/>	Yes	No	
<input type="checkbox"/>			Patient offered hereditary cancer testing? If yes, did the patient Accept or Decline: _____
<input type="checkbox"/>			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:

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