Date: ______________________

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: ______________________ **Date of Birth:** ______________________

Instructions: This is a Screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. Please note all **1st, 2nd** and **3rd** degree relatives.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**
Cousin/Great Grandparent = **3rd Degree Relatives**

BREAST AND OVARIAN CANCER	**Maternal**	**Paternal**	**RELATIONSHIP**	**AGE AT DIAGNOSIS**
Y N Breast Cancer at age 45 or younger (in self, 1st or 2nd degree relatives)	☐	☐	________	________
Y N Ovarian Cancer at **ANY AGE** (in self, 1st or 2nd degree relatives)	☐	☐	________	________
Y N Two Relatives with breast cancer on the same side of the family (one cancer occurring before age 50)	☐	☐	________	________
Y N Three of more relatives with breast cancer on the same side of the family at **ANY AGE**	☐	☐	________	________
Y N Bilateral Breast Cancer at **ANY AGE**	☐	☐	________	________
Y N Triple Negative breast cancer under the age of 60 (receptor status negative for ER, PR, HER2)	☐	☐	________	________
Y N Male Breast Cancer at **ANY AGE.**	☐	☐	________	________
Y N Breast or Ovarian cancer in Ashkenazi Jewish family members (**ANY AGE**)	☐	☐	________	________
Y N Pancreatic Cancer with 2 or more breast and/or ovarian cancers on the same side of the family	☐	☐	________	________
Y N A family member with a known BRCA Mutaion (or in self)	☐	☐	________	________

Are you Ashkenazi Jewish? ☐ Yes ☐ No

Colon and uterine Cancer	**Maternal**	**Paternal**	**RELATIONSHIP**	**AGE AT DIAGNOSIS**
Y N Uterine Cancer before age 50	☐	☐	________	________
Y N Colorectal cancer before age 50	☐	☐	________	________
Y N Two or more of the following cancers on the same side of the family: colon, Uterine (endometrial),	☐	☐	________	________
Ovarian, Stomach, Small bowel, Brain, Kidney/Urinary Tract, Ureter or Renal Pelvis (**ANY AGE)**	☐	☐	________	________
Y N A family member with a known Lynch Syndrome Mutation (or in self)	☐	☐	________	________

☐ **Patient meets criteria for genetic testing** ☐ **Patient offered genetic testing**

☐ **Patient does not meet criteria for genetic testing** ☐ **Accepted** ☐ **Declined**

Patient's Signature: ______________________ **Date:** ______________________