CANCER FAMILY HISTORY QUESTIONNAIRE

PATIENT NAME:			DATE OF BIRTH:	AGE:
GENDER (M/F):	TODAY'S DATE:	HEALTHCARE PROVIDER:		

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

NOTE: Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers. If yes, indicate family relationship and age at diagnosis in the appropriate column. **Include both sides of your family and list each member separately:** parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, half-siblings

Personal and Family History Have you or your family members been diagnosed with any of the following:	Y / N	YOU Age	SIBLINGS / CHILDREN Family Member and Age	MOTHER'S SIDE Family Member and Age	FATHER'S SIDE Family Member and Age
EXAMPLE: Breast cancer	☒ Y ◯ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer before age 50	◯ Y ◯ N				
Ovarian cancer (Peritoneal/Fallopian tube) at any age	◯ Y ◯ N				
Triple Negative Breast cancer* at age 60 or younger (ER-, PR-, HER2-Pathology)	◯ Y ◯ N				
Male Breast cancer at any age	◯ Y ◯ N				
Pancreatic cancer at any age	◯ Y ◯ N				
Metastatic Prostate cancer	◯ Y ◯ N				
Ashkenazi Jewish ancestry with **Breast** or high grade **Prostate cancer** at any age	◯ Y ◯ N				
20 or more **lifetime Colon/Rectal Polyps:** Specify number________	◯ Y ◯ N				
Colon/Rectal or **Endometrial (Uterine) cancer** before age 50	◯ Y ◯ N				
TWO individuals in my family (can include me): at least 1 with **Colon/Rectal *or* Endometrial (Uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated* cancer	◯ Y ◯ N				
THREE OR MORE individuals in my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a colorectal or endometrial (uterine) cancer	◯ Y ◯ N				

* **Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).**

Have you or a family member had genetic testing for a **hereditary cancer syndrome**?	◯ Y ◯ N	If yes, Who?___________________ What gene?__________________ What was the result? ____

PROVIDER'S SIGNATURE:	DATE:
PATIENT'S SIGNATURE:	DATE:

- Patient meets guidelines for HBOC? ◯Y ◯N Guidelines for (A)FAP? ◯Y ◯N Guidelines for Lynch? ◯Y ◯N
- $PREMM_5$ Score $\geq$ 2.5%? ◯Y ◯N If yes $PREMM_5$ Score __________%
- Genetic testing indicated? ◯Y ◯N
- Provide rationale for recommendation: ◯ Guidelines met ◯ Other (please specify): ____