HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: ______ Date of Birth: ______ Age: ______ Today's Date: ______

Instructions: This is a screening tool for cancers that run in families. Please list the age of diagnosis for each cancer that apply to YOU and/or YOUR FAMILY.

You should consider close blood relatives such as: *Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-siblings, First-Cousins, Great Grandparents and Great Grandchildren.*

TYPE OF CANCER	YOU	PARENTS/ SIBLINGS/ CHILDREN	RELATIVES		AGE at DIAGNOSIS
			MOTHER'S SIDE	FATHER'S SIDE	
BREAST CANCER (Female or Male)					
OVARIAN CANCER (Peritoneal/Fallopian Tube)					
UTERINE (ENDOMETRIAL) CANCER					
COLON/RECTAL CANCER					
10 or more GASTROINTESTINAL POLYPS *(Specify #)*					
OTHER CANCER(S) *(Specify Cancer Type)* *					

* Consider the following OTHER cancers: *Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid*

Childbirth History	Breast Biopsies
# of Pregnancies:	# of breast biopsies:
Age at first live birth:	Did any breast biopsy show atypia?

Background:

What is your ethnic background? ______ Are you of Jewish (Ashkenazi) decent? □Yes □No

# of siblings - brothers___ sisters ____ Is there a known BRCA mutation in your family?______

Have you ever been diagnosed with any or all of the following? □Breast Hyperplasia □Atypical Breast Hyperplasia □LCIS

Menstrual History:

What was your age at first period? ______ Are you currently menopausal? □Pre □Peri □Post □Unknown

Have you ever had your ovaries removed? □No □Left □Right □Both □Unknown / If yes, what age? ______

Hormone Replacement Therapy:

Have you ever used hormone replacement therapy? □Yes □No

- If yes, how many years have you taken it? ______
- If yes, how many years since last taken? ______
- If yes, what form of hormone replacement therapy? □Oral □Vaginal □Topical
- If yes, what type of hormone replacement therapy? □Estrogen □Progesterone □Combined

Patient Signature: ______

Healthcare Provider's Signature: ______

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Patient offered hereditary cancer genetic testing? □ YES □ NO □ ACCEPTED □ DECLINED

Follow-up appointment scheduled: □ YES □ NO Date of Next Appointment: ______

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
	□ 2 or more: Melanoma/Pancreatic
Young: Any one of the following at age 50 or younger	□ Breast Cancer
	□ Colorectal Cancer
	□ Endometrial Cancer
Rare: Any one of these rare presentation at any age	□ Ovarian Cancer
	□ Breast: Male Breast Cancer or Triple Negative Breast Cancer
	□ Colorectal Cancer with abnormal MSI/IHC associated histology
	□ Endometrial Cancer with abnormal MSI/IHC
	□ 10 or more gastrointestinal polyps