Hereditary Cancer Questionnaire

Personal Information

Patient Name: _____	**Date of Birth: _____**	**Today's Date: _____**	**Gender (M/F): ____**
Healthcare Provider: _____	**Age: _____**	**Reason for Visit: _____**	

Instructions: This is a screening tool for cancers that run in families. Please mark (Y) for those that apply to YOU and/or YOUR FAMILY. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family.

You and the following close blood relatives should be considered: You, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Half-Siblings, First-Cousins, Great Grandparents and Great-Grandchildren.

You and YOUR FAMILY's Cancer History (Please be as thorough and accurate as possible)

	Cancer	YOU Age of Diagnosis	PARENTS/ SIBLINGS/ CHILDREN	AGE of Diagnosis	Relatives on MOTHERS Side	AGE of Diagnosis	Relatives on FATHERS Side	AGE of Diagnosis
	Example: BREAST CANCER	*45*	*---*	*---*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	**BREAST CANCER (Female or Male)**							
☐Y ☐N	**OVARIAN CANCER (Peritoneal/ Fallopian)**							
☐Y ☐N	**UTERINE (Endometrial) CANCER**							
☐Y ☐N	**COLON/RECTAL CANCER**							
☐Y ☐N	**10 or more LIFETIME COLORECTAL POLYPS (Specify #)**							
☐Y ☐N	**OTHER CANCERS: Among others, consider the following cancers: Melanoma, Pancreatic, Stomach (Gastric), Prostate, Brain, Kidney, Bladder, Small Bowel, Sarcoma and Thyroid (Specify Other Cancer Types Below):**							

Are you of Ashkenazi Jewish descent? ○YES ○NO

Are you concerned about your personal and/or family history of cancer? ○YES ○NO

Have you or your family had genetic testing for a hereditary cancer syndrome? ○YES ○NO
(Please Explain/include a copy if possible.)

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 the 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 your healthcare provider)

Patient's Signature: _____Date: _____ Healthcare Provider's Signature: _____Date:_____

For Office Use Only: *Patient offered hereditary cancer genetic testing?* ○YES ○NO ○ACCEPTED ○DECLINED

Follow-up appointment scheduled: ○YES ○NO Date of Next Appointment:_____