HEREDITARY CANCER QUESTIONNAIRE

Personal Information

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Gender (M/F): _____ **Today's Date(MM/DD/YY):** _____ **Healthcare Provider:** _____

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, Nieces, 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 your MOTHER'S SIDE	AGE OF Diagnosis	RELATIVES on your FATHER'S SIDE	AGE OF Diagnosis
☑Y ☐N	*EXAMPLE: BREAST CANCER*	*45*	*—*	*—*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐Y ☐N	BREAST CANCER *(Female or Male)*							
☐Y ☐N	OVARIAN CANCER *(Peritoneal/Fallopian Tube)*							
☐Y ☐N	UTERINE (ENDOMETRIAL) CANCER							
☐Y ☐N	COLON/RECTAL CANCER							
☐Y ☐N	10 or more LIFETIME COLON POLYPS *(Specify #)*							
☐Y ☐N	OTHER CANCER(S) *(Specify cancer type)*	Among others, consider the following cancers: *Melanoma, Pancreatic, Stomach (Gastric), Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid, Prostate*						

☐ Y ☐ N Are you of Ashkenazi Jewish descent?

☐ Y ☐ N Are you concerned about your personal and/or family history of cancer?

☐ Y ☐ N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please explain/include a copy of result if possible)*

Hereditary Cancer Red Flags (To be completed with your healthcare provider - Check all that apply)

Hereditary Breast and Ovarian Cancer Syndrome - Red Flags*

Personal and/or family history† of:

- ☐ Breast cancer diagnosed before age 50
- ☐ Ovarian cancer
- ☐ Two primary breast cancers
- ☐ Male breast cancer
- ☐ Triple Negative Breast Cancer
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§
- ☐ Three or more HBOC-associated cancers at any age‡§
- ☐ A previously identified HBOC syndrome mutation in the family

†Close blood relatives include first-, second-, or third-degree in the maternal or paternal lineage

‡In the same individual or on the same side of the family

§HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer

Hereditary Colon Cancer - Red Flags*

An individual with any of the following:

- ☐ Colorectal or endometrial cancer before age 50
- ☐ MSI High histology before age 60¶
- ☐ Abnormal MSI\IHC tumor test result (colorectal/endometrial)
- ☐ Two or more Lynch syndrome cancers** at any age
- ☐ Lynch syndrome cancer** with one or more relatives with a Lynch syndrome cancer^
- ☐ 10 or more cumulative colorectal adenomas at any age

An individual with any of the following family histories:

- ☐ A first- or second-degree relative with colorectal or endometrial cancer before age 50
- ☐ Two or more relatives with a Lynch syndrome cancer**, one before the age of 50^
- ☐ Three or more relatives with a Lynch syndrome cancer** at any age^
- ☐ A previously identified Lynch syndrome, MAP, AFAP, or FAP syndrome mutation in the family
- ☐ One or more relatives with 10 or more cumulative colorectal polyps (adenomas) at any age

¶MSI High histology includes: Mucinous, signet ring, tumor infiltrating lymphocytes, Crohn's-like lymphocytic reaction, or medullary growth pattern

***Lynch syndrome-associated cancers include colorectal, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas*

^Cancer history should be on the same side of the family

**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'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: _____

PINELLAS HEMATOLOGY & ONCOLOGY, P.A.

Patients Name last_____First_____Today's date_____

What is the reason for your visit today?_____

What symptoms are you having now?_____

List the Doctor who referred you and any other Doctor that you have seen in the last 12 months
Doctor's Name Address City/State Phone/Fax

Please list ALL medications that you are currently taking
Name of Medication Dose Times per Day

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____

Pharmacy Name:_____Phone#_____
Location:_____
Allergies: (Include drugs that cause indigestion or do not agree with you) Latex Allergy: Yes_____No_____

1._____
2._____
3._____
4._____

Vaccines:
1. Pneumonia Month_____ Year_____
2. Flu Month_____ Year_____
Social History:

Have you ever smoked cigarettes? Yes_____ No_____ Average # of packs per day?_____
How many years?_____ Year quit?_____
Do you currently use tobacco? Yes_____ No_____
Do you consume alcohol? Yes_____ No_____ Average amount per day?_____
Do you use recreational/street drugs? Yes_____ No_____ If yes, what type?_____

Nutrition:
What is your usual weight?_____lbs. Has your weight changed?_____
Gained_____lbs. or lost_____lbs., in _____ months/years

Marital Status: Married_____Single_____Divorced_____Widower_____

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CURRENT/PAST MEDICAL HISTORY
(Check ALL that apply)

CONSTITUTIONAL:
- ☐ Good Health Lately
- ☐ Unusual Fatigue/Weakness

EYES:
- ☐ Glaucoma
- ☐ Wear Glasses/Contact Lenses
- ☐ Cataracts
- ☐ Blurred Vision
- ☐ Double Vision

ENT:
- ☐ Hard of Hearing or deaf
- ☐ Ear Infections
- ☐ Ringing in Ears
- ☐ Chronic Sinus Problems/Runny Nose
- Changes/Difficulty in:
- ☐ Taste
- ☐ Smell
- ☐ Voice

GENITOURINARY:
- ☐ Kidney Disease/Stones
- ☐ Kidney Failure
- ☐ Burning or Pain on Urination
- ☐ Blood in Urine
- ☐ Men: Prostate Problem
- ☐ Women: Menstrual Irregularity or Abnormal Bleeding
- ☐ Pelvic Pain

CARDIOVASCULAR:
- ☐ Chest Pain/Angina Pectoris
- ☐ Palpitations
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ High Cholesterol/Triglycerides

NEUROLOGICAL:
- ☐ Brain, Spinal Cord or Nerve Problems
- ☐ Light-Headedness, Dizziness or Fainting Spells
- ☐ Convulsions, Seizures, Spasms, Epilepsy
- ☐ Stroke/TIA or Paralysis
- ☐ Head Injury
- ☐ Numbness, Tingling
- ☐ Tremors

RESPIRATORY:
- ☐ Chronic or Frequent Cough
- ☐ Bloody Sputum
- ☐ Shortness of Breath
- ☐ Asthma/Recurrent Wheezing
- ☐ Emphysema
- ☐ Pneumonia

GASTROINTESTINAL:
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Indigestion/Dyspepsia
- ☐ Stomach Fluid Refluxing Into Mouth
- ☐ Peptic Ulcers
- ☐ Hiatal Hernia
- ☐ Trouble/Pain Swallowing
- ☐ Lump or Sensation in Throat
- ☐ Food Sticking
- ☐ Upper Abdominal Pain
- ☐ Bloating
- ☐ Belching
- ☐ Lower Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding
- ☐ Black or Tarry Stools
- ☐ Hidden Blood in Stool
- ☐ Excessive Rectal Gas/Flatus
- ☐ Loss of Stool/Fecal Accident
- ☐ Anemia
- ☐ Chronic Aspirin Use
- ☐ Poor Appetite
- ☐ Pancreas Problems
- ☐ Hepatitis or in the Past
- ☐ Transfusion
- ☐ Jaundice or Liver Problems

HEMATOLOGIC/LYMPHATIC/ CANCER:
- ☐ Anemia
- ☐ Bleeding, Clotting or Bruising Tendency
- ☐ Sickle Cell Trait or Disease
- ☐ Swelling/Warmth/Tenderness of Veins/Phlebitis
- ☐ Lumps or Swollen Glands in Neck
- ☐ Leukemia
- ☐ Blood Transfusion Year:_____
- ☐ Cancer: Type:_____
  _____
  _____
  Year:_____

FAMILY HISTORY OF CANCER:
Relationship:_____
_____
Type:_____
_____
_____
_____
Relationship:_____
_____
Type:_____
_____
_____
Relationship:_____
_____
Type:_____
_____
_____
_____

INFECTIOUS DISEASES:
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Tuberculosis
- ☐ TB Exposure
  - ☐ Night Sweats
  - ☐ Cough
  - ☐ Fever

ENDOCRINE:
- ☐ Glandular or Hormone Problem
- ☐ Heat or Cold Intolerance
- ☐ Excessive Skin Dryness
- ☐ Excessive Thirst or Urination
- ☐ Weight Problem
- ☐ Diabetes
- ☐ Hypothyroidism/Goiter
- ☐ Hyperthyroidism

SKIN/BREAST:
- ☐ Rashes or Itching
- ☐ Change in Skin Color or Moles
- ☐ Varicose Veins
- ☐ Breast Pain/Lump
- ☐ Breast Discharge or Rash

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MUSCULOSKELETAL:
- ☐ Joint Pain/Arthritis
- ☐ Weakness of Muscles or Joints
- ☐ Back Pain
- ☐ Gout
- ☐ Osteoporosis
- ☐ Neck/Back Pain

_____

SURGERY/ANESTHESIA/SCREENING:
Last Mammogram:_____
Last PSA:_____
Last Colonoscopy:_____
- ☐ Problems with Anesthesia
- ☐ Operations

Type & Year

_____
_____
_____
_____
_____

PSYCHIATRIC:
- ☐ Anxiety/Agitation
- ☐ Depression
- ☐ Crying for No Reason
- ☐ Insomnia
- ☐ Alcoholism
- ☐ Drug Problem (Now/Past)

Describe you mood/spirit:_____
_____
Do you feel depressed?_____
What is your biggest worry?_____
_____
_____
Other issues:_____
_____
_____

FOR WOMEN:
How old were you when your menstrual cycle began?_____
What age at Menopause?_____
Date of last menstrual cycle?_____
Past Pregnancy? Yes_____ How many children?_____
Is there a possibility you might be pregnant?_____
Have you taken birth control pills?_____ If yes, at what age did you start_____ stop_____
Have you ever taken hormone replacement? Yes_____ No_____ How long?_____

OTHER PAST ILLNESSES:
_____
_____
_____
_____

LIVING WILL:
Do you have a Living Will? Yes_____ No_____
If no, do you want information: Yes_____ No_____
Who is your healthcare surrogate?_____

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