Hereditary Cancer Family History Information

Patient/Physician Information

Patient's name: ______________________ / Date of birth: ______________

Physician's name: ______________________ / Date: ______________

Instructions: Please indicate your family's history of cancer in the table below. Check Yes for the cancer(s) that apply to you and/or your blood relatives. Please list the relative, side of the family, and age of diagnosis for each cancer type.

Blood relatives to consider: parents, children, siblings, half-siblings, aunts, uncles, cousins, nieces, nephews, and grandparents

Are you of Ashkenazi Jewish descent? ❍ Yes ❍ No

Patient/Family Cancer History

Please fill in as completely as possible		Your Age at Diagnosis	Family Member	Side of the Family Mother's or Father's	Age at Diagnosis
Example: Breast	✔ Yes ❍ No	53	Mother Grandmother Aunt	– Mother's Father's	65 62 55
Breast (one breast)	❍ Yes ❍ No				
Breast (both breasts or multiple primary breast cancers)	❍ Yes ❍ No				
Was the breast cancer triple negative?	❍ Yes ❍ No	❍ Unknown	**Who:**		
Ovarian (Fallopian Tube, Peritoneal)	❍ Yes ❍ No				
Pancreatic	❍ Yes ❍ No				
Prostate	❍ Yes ❍ No				
Uterine (endometrial)	❍ Yes ❍ No				
Colorectal	❍ Yes ❍ No				
Stomach	❍ Yes ❍ No				
Other – *Please specify* *Examples of other cancers: melanoma, kidney/urinary tract, brain, or small bowel*	❍ Yes ❍ No				

Have you or any of your family members had genetic testing for any hereditary risk of cancer? ❍ Yes ❍ No

If yes, please explain: ______________________

____

Patient's Signature (required): ______________________ **Date:** ______________

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Patient appropriate for further risk assessment or genetic testing? ❍ Yes ❍ No

❍ Patient offered genetic testing? ❍ Accepted ❍ Declined

❍ Patient offered genetic counseling? ❍ Accepted ❍ Declined

Physician's signature: ______________________ **Date :** ______________

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