

# CANCER FAMILY HISTORY QUESTIONNAIRE

## Personal Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Gender (M/F): \_\_\_\_\_ Today's Date(MM/DD/YY): \_\_\_\_\_ Health Care 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
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	<b>EXAMPLE:</b> BREAST CANCER	45	-----	---	Aunt Cousin	45 61	Grandmother	53
<input type="checkbox"/> Y <input type="checkbox"/> N	BREAST CANCER (Female or Male)							
<input type="checkbox"/> Y <input type="checkbox"/> N	OVARIAN CANCER (Peritoneal/Fallopian Tube)							
<input type="checkbox"/> Y <input type="checkbox"/> N	UTERINE (ENDOMETRIAL) CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	COLON/RECTAL CANCER							
<input type="checkbox"/> Y <input type="checkbox"/> N	10 or more LIFETIME COLON POLYPS (Specify #)							
<input type="checkbox"/> Y <input type="checkbox"/> 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<sup>†</sup> 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<sup>‡§</sup>
- Three or more HBOC-associated cancers at any age<sup>‡§</sup>
- A previously identified HBOC syndrome mutation in the family

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

<sup>‡</sup>In the same individual or on the same side of the family

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

### Lynch Syndrome - Red Flags\*

#### An individual with any of the following:

- Colorectal or endometrial cancer before age 50
- MSI High histology before age 60<sup>¶</sup>
- 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<sup>^</sup>
- A previously identified Lynch syndrome or MAP syndrome mutation in the family

#### 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<sup>^</sup>
- Three or more relatives with a Lynch syndrome cancer\*\* at any age<sup>^</sup>
- A previously identified Lynch syndrome or MAP syndrome mutation in the family

<sup>¶</sup>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

<sup>^</sup>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](http://www.MyriadPro.com)

## Cancer Risk Assessment Review (To be completed after discussion with healthcare provider)

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Care 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: \_\_\_\_\_