

CANCER FAMILY HISTORY 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
<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	EXAMPLE: 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	ENDOMETRIAL (Uterine) 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/RECTAL 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), Prostate, Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid						

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)

If Yes, Who? _____ What gene(s)? _____ What was the result? _____

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:

<input type="checkbox"/>	Multiple A combination of cancers on the same side of the family:	<input type="checkbox"/> 2 or more: breast / ovarian / prostate / pancreatic cancer <input type="checkbox"/> 2 or more: colon/rectal / endometrial / ovarian / gastric / pancreatic / other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas) <input type="checkbox"/> 2 or more: melanoma / pancreatic
<input type="checkbox"/>	Young Any 1 of the following at age 50 or younger :	<input type="checkbox"/> Breast cancer <input type="checkbox"/> Colon/rectal cancer <input type="checkbox"/> Endometrial cancer
<input type="checkbox"/>	Rare Any 1 of these rare presentations at any age :	<input type="checkbox"/> Ovarian cancer (Peritoneal/Fallopian tube) <input type="checkbox"/> Breast: Male breast cancer or Triple negative breast cancer [¶] (ER-, PR-, HER2- Pathology) <input type="checkbox"/> Ashkenazi Jewish ancestry with an HBOC-associated cancer [¶] <input type="checkbox"/> Colon/rectal cancer with abnormal MSI/IHC, or MSI high associated histology ^{††} <input type="checkbox"/> Endometrial cancer with abnormal MSI/IHC <input type="checkbox"/> 10 or more colon/rectal polyps*

[¶] HBOC-Associated cancers include breast (including DCIS), ovarian, pancreatic, and aggressive prostate cancer (Gleason Score ≥ 7)

^{††} 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 healthcare provider)

Patient's Signature: _____ Date: _____

Healthcare Provider's Signature: _____ Date: _____

Office Use Only:

Patient offered hereditary cancer genetic testing? YES NO ACCEPTED DECLINED

If YES, which test? BRACAnalysis[®] with Myriad myRisk[®] Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk

COLARIS^{®PLUS} with Myriad myRisk COLARIS AP^{®PLUS} with Myriad myRisk Single Site Testing Myriad myRisk Update Other: _____

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

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