

CANCER HISTORY QUESTIONNAIRE

Patient Name: _____ Provider (today's visit): _____

Date of Birth: _____ Date: _____

Have you completed this questionnaire in the last 12 months? Yes/No

This is a screening tool for cancers that run in families. Please consider these family members when completing the form and answer each question separately: Mother/Father, Siblings, Children, Half-siblings, Aunts/Uncles, Grandparents, Nieces/Nephew, Grandchildren, 1st cousin and Great-grandparents

*****If your history exactly matches these questions check Y*****

If you are unsure of the exact age of diagnosis please indicate whether the diagnosis was above or below the age of 50 by writing 45 for below 50 diagnoses and 55 for above 50 diagnoses.

Cancer Family History	Check Y or N	Please list yourSELF or your FAMILY MEMBER listed above with CANCER			Age of Diagnosis
		SELF	MOTHER'S SIDE	FATHER'S SIDE	
Colon Cancer diagnosed before age 50	Y N <input type="checkbox"/> <input type="checkbox"/>				
Endometrial/Uterine Cancer diagnosed before age 50 (Including yourself if diagnosed at any age)	Y N <input type="checkbox"/> <input type="checkbox"/>				
Three or more of the following cancers on the same side the family at any age (including yourself): Colon, Endometrial, Ovarian, Gastric/Stomach, Pancreatic, Brain, Small Bowel, Renal/Pelvic, Biliary Tract, Sebaceous Adenomas	Y N <input type="checkbox"/> <input type="checkbox"/>				
Breast Cancer diagnosed at age 50 or less (Including yourself if Triple Negative Breast Cancer diagnosed ≤ 60)	Y N <input type="checkbox"/> <input type="checkbox"/>				
Ovarian Cancer at any age	Y N <input type="checkbox"/> <input type="checkbox"/>				
One relative with breast cancer (could include yourself) diagnosed at age ≤ 50 and another relative with pancreatic or prostate at any age	Y N <input type="checkbox"/> <input type="checkbox"/>				
Three or more of the following cancers on the same side of the family regardless of age (could include yourself): Breast, Ovarian, Pancreatic and/or Prostate	Y N <input type="checkbox"/> <input type="checkbox"/>				
Male breast cancer diagnosed at any age	Y N <input type="checkbox"/> <input type="checkbox"/>				
Ashkenazi Jewish ancestry with one breast, ovarian or pancreatic cancer in the family (could include yourself)	Y N <input type="checkbox"/> <input type="checkbox"/>				
Have you ever been tested for BRCA or Lynch Syndrome before? <input type="checkbox"/> Y <input type="checkbox"/> N					

FOR OFFICE USE ONLY

- Patient is NOT appropriate for testing
- Patient is appropriate for testing
- Patient offered genetic testing: Accepted OR Declined
- HCP Signature: _____