CANCER FAMILY HISTORY QUESTIONNAIRE (updated 3/19)

Your family history is important to your healthcare. This is a screening tool for the common features of hereditary cancers.

Patient Name: _____ **Date of Birth:** _____ **Gender**: MALE FEMALE

Today's Date: _____ **Address:** _____

Patient Ethnicity (CIRCLE): White/Non-Hispanic Hispanic/Latino Black/African Ashkenazi Jewish Asian Native American Pacific Islander Middle Eastern Other:_____

Are you of Ashkenazi Jewish ancestry? **YES** **NO**

Have **YOU** ever had **BREAST, OVARIAN, COLON, UTERINE (Endometrial), Pancreatic, or Metastatic Prostate Cancer:** **YES** **NO**

Cancer: _____ ***Age of diagnosis**_____

*NCCN 2019: Personal diagnosis of Breast cancer > 50, Personal diagnosis of Colon or Uterine cancer > 64, Personal or Family History of Pancreatic Cancer at any age. ASBS 3/19 Personal diagnosis of breast cancer at any age.

Please include the following family members:

Mother/Father/Sister/Brother/Daughter/Son, Aunt/Uncle/Grandmother/Grandfather/Niece/Nephew, Cousins/Great-grandparents

Breast and Ovarian Cancer Family History			Which Family Member(s)		Age of Cancer
			Mom's Family	Dad's Family	
Y	N	Family member who had **breast** cancer **BEFORE AGE 50**			
Y	N	Family member who had **ovarian or pancreatic** cancer **AT ANY AGE**			
Y	N	Three family members, **ON THE SAME SIDE** of the family, who had **breast, pancreatic, or prostate** cancer **AT ANY AGE**			
Y	N	Family member who had triple negative breast cancer **before age 60** *(ER, PR, and HER2 negative receptor status)*			
Y	N	One family member who had **multiple breast** cancers (in the same breast OR both breasts)			
Y	N	Family member who had **MALE BREAST CANCER AT ANY AGE**			
Y	N	Family member who had **metastatic prostate** cancer **AT ANY AGE**			

Colon and Endometrial (Uterine) Cancer Family History			Mom's Family Cancer	Dad's Family Cancer	Age of Cancer
Y	N	Family member who had **uterine** cancer **BEFORE AGE 50**			
Y	N	Family member who had **colon** or **rectal** cancer **BEFORE AGE 50**			
Y	N	Three family members, **ON THE SAME SIDE**, who have had colon/rectal or uterine cancer **AT ANY AGE**			
Y	N	Any family members with the following cancers? **CIRCLE**: stomach, small bowel, brain, pancreas, kidney/urinary tract, ureter or renal pelvis			

PLEASE TURNOVER AND COMPLETE THE BACK *ONLY* IF YOU ANSWERED *'YES'* TO ANY OF THE ABOVE QUESTIONS ON THE GRID.

CANCER RSK ASSESSMENT REVIEW: To be completed with your healthcare provider

Patient Signature: _____ **Date:** _____

Healthcare Provider Signature: _____ **Date:** _____

Office Use Only:
Patient appropriate for hereditary cancer genetic testing? □ **YES** □ **NO**
Patient was offered genetic testing? □ **ACCEPTED** □ **DECLINED**
Follow-up appointment scheduled: □ **YES** □ **NO**

OVER →

BREAST CANCER RISK MODEL INFORMATION:

ONLY COMPLETE IF YOU ANSWERED 'YES' TO ANY OF THE QUESTIONS IN THE GRID ON THE PREVIOUS PAGE

Height (ft./in):	**Weight (lbs.):**
How old were you when you got your first menstrual period: _____	
Are you: □ Pre-menopausal □ Peri-menopausal* □ Post-menopausal*: Age of onset_____	
Have you had a live childbirth? **YES** **NO** How old were you at your first child's birth_____	
Have you ever used Hormone Replacement Therapy? YES NO **IF YES, Treatment Type:** □ Combined □ Estrogen Only □ Progesterone Only **IF YES, is patient a** □ Current User: Started_____ years ago Intended use for _____more years □ Past User: Stopped_____ years ago	
Have you had breast biopsy? YES NO **IF YES, Did it show:** □ No Benign Disease □ Hyperplasia □ Atypical Hyperplasia □ LCIS □ Biopsy □ Result Unknown	

*Peri-menopausal: time before menopause marked by irregular periods. Post-menopausal: permanent cessation of period for 12 months or longer.

Female Relatives Information

How many daughters do you have?	
How many sisters do you have?	
How many sisters does your mother have?	
How many sisters does your father have?	