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Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ **Date of Birth:** ____________

Physician: _____ **Date completed:** ____________

Date(s) updated: ____________

Please circle 'Y' next to all of the statements that apply to you and/or close family members, including **first degree** (i.e. parents, siblings, children), **second degree** (i.e. aunts, uncles, grandparents, grand- children) and **third degree** (i.e. cousins, great grandparents) relatives. Then list your relationship to the individual diagnosed along with their age at diagnosis. Please note, this is a screening tool to help identify patients with a higher chance to have a common hereditary cancer syndrome in their family. If you circle 'Y' to any statements below, your doctor MAY determine that genetic testing is appropriate.

Do you have any Ashkenazi Jewish ancestry? ☐ yes ☐ no

Yes	No	Personal or Family History of Cancer	Relationship *(self, cousin)*	Maternal *(mother's side)*	Paternal *(father's side)*	Age(s) of Diagnosis
Hereditary Breast and Ovarian Cancer						
Y	N	Breast cancer before age 50				
Y	N	Ovarian cancer *Includes cancers of the ovaries, fallopian tubes, and peritoneum*				
Y	N	More than one separate breast cancer diagnosis In either same breast and/or other breast				
Y	N	Male breast cancer				
Y	N	Triple negative breast cancer* diagnosed at age <= 60 **ER-/PR-/HER2-*				
Y	N	Pancreatic cancer				
Y	N	Metastatic*/high-grade† prostate cancer **cancer spread to other parts of the body †Gleason score >7*				
Y	N	3 or more breast cancers on same side of family				

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Yes	No	Personal or Family History of Cancer	Relationship *(self, cousin)*	Maternal *(mother's side)*	Paternal *(father's side)*	Age(s) of Diagnosis
Hereditary Colon Cancer						
Y	**N**	Colorectal cancer before age 50				
Y	**N**	Uterine (endometrial) cancer before age 50				
Y	**N**	More than 1 of the following cancers/skin findings in **same individual**: *Cancers:* colon, uterine, ovarian, stomach, kidney/urinary tract, brain, small bowel Skin findings: sebaceous adenomas/carcinomas or keratoacanthomas of family				
Y	**N**	3 or more of the following cancers/skin findings on **same side of family**: *Cancers:* colon, uterine, ovarian, stomach, kidney/urinary tract, brain, small bowel Skin findings: sebaceous adenomas/carcinomas or keratoacanthomas				
Y	**N**	Multiple colon polyps in same individual *Includes 10 or more adenomatous polyps, 2 or more hamartomatous polyps, OR 5 or more serrated polyps*				

Additional cancer-related history, including other cancer diagnoses (i.e. sarcoma, brain cancer), skin findings (pathognomonic skin lesions, mucocutaneous hyperpigmentation) and skeletal findings (i.e. macrocephaly):* _____

_____

_____

**Please be sure to discuss with your healthcare provider any history of other cancers, known familial variant(s), and/or positive test results from cancer/tumor testing that may suggest a hereditary cancer syndrome.*

For office use only:

Information given to patient to review: Y/N

Candidate for further risk assessment and/or genetic testing: Y/N

Patient offered Genetic Testing: Y/N Accepted: ____ Declined: ____

Follow up appointment scheduled for results: _____

Patient's Signature: _____

Date :____________

Health Care Provider's Signature: _____

Date: ____________

NOTE: Further discussion may be warranted for patients not flagged using the above criteria but with >2.5% chance of a *BRCA1/2* pathogenic variant based on prior probability models (i.e. Tyrer-Cuzick, BRCAPro, etc) or for patients who may benefit from genetic testing for therapeutic decision-making.