We are committed to your health through cancer prevention.

Please fill out this brief questionnaire as thoroughly as possible so that we are better prepared to help you.

If you filled out this form within the last 6 months and nothing has changed, please initial here:

_____

TURN OVER

Screening: Your Personal and Family History of Cancer

Patient Name: _____ Date of Birth: _____

If you have a **personal or family history** of the following cancers, please indicate **WHO** and **AGE at diagnosis**. Include parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, great aunts/uncles, great grandparents and cousins.

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	**EXAMPLE:** *Breast Cancer*	_____	_____	*Aunt 53*	*Grandmother 45*
Y	N	**Breast Cancer**				
Y	N	**Ovarian Cancer** ***(Peritoneal/Fallopian Tube)***				
Y	N	**Are you of Ashkenazi Jewish descent?**				
Y	N	**Colon/Rectal Cancer**				
Y	N	**Endometrial (Uterine) Cancer**				
Y	N	**10 or more colon polyps in a lifetime** ***(Specify #)***				
Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lynch)**				
Y	N	**Melanoma**				
Y	N	**Other Cancers**				
Y	N	**Have you or anyone in your family had genetic testing for a cancer syndrome?** **If YES, WHEN: _____ RESULTS:_____**				

Please complete this section if you are a FEMALE WITHOUT BREAST CANCER:

Your current height (ft/in) _____

Your current weight (lbs) _____

Your menopausal status:

☐ Pre-menopausal

☐ Peri-menopausal
(time before menopause marked by irregular cycles)

☐ Post-menopausal
(permanent cessation of period for 12 months or longer)

Age of onset _____

Your age at time of first menstrual period _____

Your age at time of first live birth: _____

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ Don't know

If yes, are you a: ☐ Current user: How many years ago did you start? _____
How many more years do you intend to use? _____

☐ Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? _____

Number of daughters _____

Number of sisters _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

Patient's Signature: _____Date:_____

FOR OFFICE USE ONLY:

Patient meets guidelines for testing: ☐ YES ☐ NO CLINICIAN SIGNATURE: _____

IF YES: ☐ ACCEPTED ☐ DECLINED If Declined: Counseling Provided and Patient Signed:_____

HEREDITARY BREAST AND OVARIAN CANCER (HBOC): PERSONAL or FAMILY History

ONE person with (out to 2nd degree):

*Breast Cancer under 50
*Ovarian Cancer any age
*Pancreatic Cancer any age
*Metastatic Prostate Cancer any age
*Triple Negative Breast Cancer under 60
*Male Breast Cancer any age
*Breast Cancer any age and Ashkenazi
*Pancreatic Cancer any age and Ashkenazi

TWO persons with (out to 3rd degree):

*Breast Ca, 1 under 50
*Breast Ca and Ovarian Ca any age

THREE persons with (out to 3rd degree):

*Breast and/or Pancreatic and/or Ovarian and/or Prostate (Gleason > 6) any age

LYNCH SYNDROME: Personal or Family History**

ONE person with (out to 2nd degree):

*Endometrial Cancer under 50
*Colon Cancer under 50

TWO persons with (out to 2nd degree):

*Endo or Colon Ca over 50 and a Lynch cancer < 50

THREE persons with (out to 3rd degree):

*Lynch cancers, 1 being Endo or Colon, any age

FAP/AFAP: Personal or Family History

ONE person with (out to 2nd degree):

*10 or more colon polyps in a lifetime

**Lynch cancers: Endo, CRC, Ovarian, Stomach, Brain, Pancreas, Small Bowel, Biliary Tract, Ureter/Renal Pelvis, Sebaceous Adenoma

1st degree: parents, siblings, children. **2nd degree**: grandparents, aunts/uncles, nieces/nephews, ½ siblings. **3rd degree**: great grandparents, great aunts/uncles, 1st cousins.