Hereditary Cancer Family History Questionnaire

Patient Information

Patient's Name _____ DOB: MM/DD/YYYY _____

Age _____ Biological Sex (Male/Female) _____

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.

Do you have a personal history of	Y/N	Cancer Type?	Age at Diagnosis?
Breast, ovarian, metastatic prostate, or pancreatic cancer?			
Colorectal or uterine cancer diagnosed before age 50?			

Please consider the following biological relatives: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces, and nephews on both sides of the family.

Do you have a family history of	Y/N	Which Relative?	Maternal or Paternal?	Age at Diagnosis?
Breast cancer under age 50				
Ovarian cancer at any age				
Pancreatic cancer at any age				
Metastatic prostate cancer at any age				
Male breast cancer at any age				
Colon cancer under age 50				
Uterine cancer under age 50				
Jewish ancestry				
Have you or has anyone in your family had genetic testing for hereditary cancer?			**What genes?**	**What was the result?**

Patient's Signature: _____ Date: _____

Office Use Only
Patient meets hereditary cancer testing criteria: ☐Y ☐N
Testing Offered: ☐ Accepted ☐ Declined

Health Care Provider's Signature: _____ Date: _____

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