SWEDISH MEDICAL GROUP

PATIENT LABEL HERE

Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date completed: _____

Instructions: Please circle Y to those that apply to YOU and/or YOUR FAMILY (on both your **mother's or father's side**). Behind each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and their age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes, if you circle Y to any statements below, you MAY be appropriate for genetic testing. Ask your healthcare provider for additional information.

BREAST AND OVARIAN CANCER (BRCA)	RELATIONSHIP	AGE AT DIAGNOSIS
Y N - Breast cancer before age 50	_____	_____
Y N - Ovarian cancer at any age	_____	_____
Y N - Breast cancer in both breasts or multiple primary breast cancers	_____	_____
Y N - Both breast & ovarian cancer (in an individual or family)	_____	_____
Y N - Male breast cancer	_____	_____
Y N - 2 or more breast or ovarian cancers (in an individual or a family)	_____	_____
Y N - Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer	_____	_____
Y N - Are you of Jewish descent?	_____	_____
Y N - Patient has breast cancer diagnosed after age 50 has I relative with breast cancer	_____	_____
Y N - Any unaffected patient with 3 relatives with Breast cancer, regardless of age	_____	_____
Y N - Family member with known BRCA mutation	_____	_____
COLON AND UTERINE CANCER (COLARIS)		
Y N - Uterine cancer before age 50	_____	_____
Y N - Colorectal cancer before age 50	_____	_____
Y N - Both uterine & colorectal cancer (in an individual or family)	_____	_____
Y N - 2 or more uterine or colorectal cancers (in an individual or a family)	_____	_____
Y N - Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)	_____	_____
COLARIS AP		
Y N - 10 or more colon polyps found in a lifetime (in an individual or a family)	_____	_____

☐ Candidate for further risk assessment and/or genetic testing

☐ Information given to patient to review

☐ Follow up appointment scheduled Date: _____

☐ Patient offered genetic testing

☐ **Accepted** ☐ **Declined**

_____ _____

Patient's Signature Date Health Care Provider's Signature Date