SWEDISH
MEDICAL GROUP

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Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name:_____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please check **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 ages 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.

			RELATIONSHIP	AGE AT DIAGNOSIS
BREAST AND OVARIAN CANCER (BRCA)				
☐ Y	☐ N	Breast cancer before 50		
☐ Y	☐ N	Ovarian cancer at any age		
☐ Y	☐ N	Breast cancer in both breasts or multiple primary breast cancer		
☐ Y	☐ N	Both breast & ovarian cancer (in an individual or a 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 decent?		
☐ Y	☐ N	Patient has breast cancer disgnosed after age 50 and has 1 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 a family)		
☐ Y	☐ N	2 or more uterine or colorectal cancers (in an individual or family		
☐ Y	☐ N	Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)		
☐ Y	☐ N	10 or more colon polys found in a lifetime (in an individual or a family)		

☐ Canidate for further risk assessment and/or genetic testing ☐ Patient offered genetic testing
☐ Information given to patient to review ☐ Accepted ☐ Declined
☐ Follow up appointment scheduled Date: _____

X _____ _____
Patient's Signature Date Healthcare Provider's Signature Date