

## Family History Questionnaire for Common Hereditary Cancer Syndromes

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_

Date: \_\_\_\_\_

Please mark below if there is any personal or family history of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles and cousins.

	You	Siblings/ Children	Mother's Side	Father's Side
For Example: Colorectal Cancer		Brother 36 yrs	Aunt 44 yrs Cousin 58 yrs	Grandfather 65yrs

### Breast & Ovarian Cancer

Breast Cancer				
Ovarian Cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				
Are you of Ashkenazi Jewish decent?				

Patient given information to review  
 Patient offered genetic testing  
      Accepted    Declined  
 Follow up appointment scheduled  
 Date: \_\_\_\_\_