

Cancer History Questionnaire

To assess your personal hereditary cancer risk, please complete the questionnaire below and return it to your healthcare provider. Studies have demonstrated that some individuals and families are at increased risk of developing specific cancers based on their genetic information. By reviewing your personal and family history, your healthcare provider can determine whether or not you are a candidate for genetic testing.

Please indicate below whether there is a personal or family history for any of the listed cancers. Review each cancer individually noting that the same cancer diagnosis may be listed more than once. Be sure to consider parents, children, brothers, and sisters as well as grandparents, aunts, uncles, and cousins on both sides of your family. If there is a personal or family history for any of the listed cancers, be sure to also indicate the age at diagnosis and family relationship in each instance.

Patient Name: _____ **Date of Birth:** _____ **Gender:** Male Female
Race/Ethnicity: African American/Black Caucasian Jewish (Ashkenazi) Other:
 Asian Hispanic Native American
Email Address: _____ **Telephone:** _____ **Date:** _____
Insurance Carrier: _____ **Policy ID #:** _____
Doctor's Name: _____ **Best way to contact you:** Phone Email

Patient Previous Genetic Testing:

No history of Genetic Testing Positive test: BRCA1 BRCA2 Negative test: BRCA1 BRCA2
 Other (specify): _____

Patient Personal History:

Is there any cancer in your personal history? No personal history Yes: please specify below

Personal Cancer Site	Age at Diagnosis	Notes
<input type="checkbox"/> Breast		<input type="checkbox"/> Multiple Tumors <input type="checkbox"/> Premenopausal
<input type="checkbox"/> Colon/Rectal		
<input type="checkbox"/> Ovarian		
<input type="checkbox"/> Pancreatic		
<input type="checkbox"/> Prostate		<input type="checkbox"/> High Grade <input type="checkbox"/> Metastatic Gleason: 2 3 4 5 6 7 8 9 10
<input type="checkbox"/> Uterine/Endometrial		
<input type="checkbox"/> Other (specify):		

Family History:

Is there a known family history of BRCA genes mutations? No family history Yes: BRCA1 BRCA2 Other (specify):
 (Please include a copy of the family mutation report.)

Is there any cancer in the family history? No family history Unknown Yes: please specify below

Please provide as much detail as possible. If unsure of age, please provide an estimate.

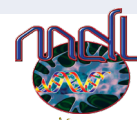
Cancer Site	Relationship			Age			Notes
	Immediate Family	Maternal	Paternal	At Diagnosis	Current	At death	
Example:	Father		Aunt	60	65	70	
<input type="checkbox"/> Breast							<input type="checkbox"/> Multiple Tumors <input type="checkbox"/> Cancer in both breasts <input type="checkbox"/> Triple negative breast cancer
<input type="checkbox"/> Colon/Rectal							
<input type="checkbox"/> Ovarian							
<input type="checkbox"/> Pancreatic							
<input type="checkbox"/> Prostate							<input type="checkbox"/> Gleason score of 7 or higher <input type="checkbox"/> Metastatic <input type="checkbox"/> High grade
<input type="checkbox"/> Uterine/Endometrial							
<input type="checkbox"/> Other (specify):							

A genetic consultant will contact you to schedule a time to review your personal and family history. For taking the time to submit the questionnaire, a donation will be made to cancer research.



Division of Genetics & Oncology

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