

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:
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Family History Questionnaire

Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text **EMPOWER to 484848.**

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

Please complete the following for you and your family members:			Age at diagnosis		Enter family member and age at diagnosis		
			You		Siblings/Children	Mother's side	Father's side
Example:	Breast cancer	<input checked="" type="checkbox"/> Y <input type="checkbox"/> N	Age 46		Daughter, 23 Sister, 52	Aunt, #1 63 Aunt, #2 48	Grandma, 81
1.	Breast cancer < age 50	<input type="checkbox"/> Y <input type="checkbox"/> N					
2.	Either colon cancer or uterine cancer < age 50	<input type="checkbox"/> Y <input type="checkbox"/> N					
3.	Triple negative breast cancer ≤ age 60	<input type="checkbox"/> Y <input type="checkbox"/> N					
4.	Two or more breast cancers in the same person (first diagnosis ≤ age 50)	<input type="checkbox"/> Y <input type="checkbox"/> N					
5.	Two or more colon and/or uterine cancers in the same person	<input type="checkbox"/> Y <input type="checkbox"/> N					
6.	Two family members with breast, colon or uterine cancer (one ≤ age 50)	<input type="checkbox"/> Y <input type="checkbox"/> N					
7.	Three or more family members from the same side with breast cancer	<input type="checkbox"/> Y <input type="checkbox"/> N					
8.	Three or more family members with colon and/or uterine cancer	<input type="checkbox"/> Y <input type="checkbox"/> N					
9.	Ovarian cancer OR pancreatic cancer OR male breast cancer OR 10 or more precancerous colorectal polyps	<input type="checkbox"/> Y <input type="checkbox"/> N					
10.	Ashkenazi Jewish AND breast cancer or prostate cancer	<input type="checkbox"/> Y <input type="checkbox"/> N					
11.	You or a close family member has a known gene mutation. Please list _____	<input type="checkbox"/> Y <input type="checkbox"/> N					
12.	Other cancers not listed above _____	<input type="checkbox"/> Y <input type="checkbox"/> N					
13.	Other concern about your cancer risk	<input type="checkbox"/> Y <input type="checkbox"/> N	Please explain:				

Signatures

_____ Patient Name	_____ Patient Signature	_____ Date
_____ Provider Name	_____ Provider Signature	_____ Date

For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

Patient offered hereditary cancer genetic testing
(check all that apply)

Yes
 No
 Patient accepted
 Patient declined