Family History Questionnaire

MRN# _____

Name _____ Date of Birth _____ Date: _____

I HAVE HAD HEREDITARY FAMILY CANCER GENETIC TESTING: ❑YES ❑NO

If YES, Please Indicate your RESULTS: ❑ Negative ❑Positive, Gene:_____

******If you have already had cancer genetic testing done, you DO NOT need to fill out this questionnaire***

Based on the family history information you provide here, you MAY be appropriate for genetic testing and your provider MAY be able to change your medical management to improve your care. Please circle yes to those that apply to you and/or your family. Consider these family members when completing the form (Both Maternal AND Pternal sides of the family):

Mother/Father/Sister/Brother/Children = **1st Degree Blood Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Blood Relatives**

			Specify Relative(s):	*Age of Diagnosis:*
Breast Cancer before age 50	YES	NO		
Ashkenazi Jewish Ancestry with breast cancer at any age	YES	NO		
Ovarian Cancer at any age	YES	NO		
Breast Cancer in both breasts (Bilateral) at any age	YES	NO		
3 Breast Cancers on the same side of the family at any age	YES	NO		
Male Breast Cancer at any age	YES	NO		
Pancreatic Cancer at any age	YES	NO		
Uterine Cancer before age 50 (or before 65 in YOURSELF)	YES	NO		
Colorectal Cancer before age 50 (or before 65 in YOURSELF)	YES	NO		
3 or more of the following cancers on the same side of the family: Uterine, Colorectal, Stomach	YES	NO		
Have you been personally diagnosed with Breast Cancer	YES	NO		
Do you plan to become pregnant in the next year?	YES	NO		

Patient Signature: _____ **Provider you are seeing today:** _____

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Patient is a candidate for genetic testing: YES NO.

_____Genetic testing information provided ____Genetic testing Completed ___Genetic testing Decline

Provider's Signature:_____