Family History Questionnaire

PATIENT INFORMATION

Patient's first name	Patient's last name	Age	Date of birth (MM/DD/YYYY)
Sex	Today's date (MM/DD/YYYY)	Healthcare provider	

YOU AND YOUR FAMILY'S CANCER HISTORY (please be as thorough and accurate as possible)

This is a screening tool for cancers that run in families. Next to each statement, please list the relationship(s) to you and age of diagnosis for each cancer in your family. **You and the following close blood relatives should be considered:** You, parents, brothers, sisters, sons, daughters, grandparents, grandchildren, aunts, uncles, nephews, nieces, half-Siblings, first-Cousins, great-grandparents and great-grandchildren.

Cancer	Personal/family history?	Your age of diagnosis	Parents/siblings/children (include their sex and age of diagnosis)	Relatives on mother's side (include their sex and age of diagnosis)	Relatives on father's side (include their sex and age of diagnosis)
Breast (male or female)	◯ Yes ◯ No				
Ovarian (peritoneal/ fallopian tube)	◯ Yes ◯ No				
Uterine (endometrial)	◯ Yes ◯ No				
Colon/rectal	◯ Yes ◯ No				
10 or more lifetime colorectal polyps	◯ Yes ◯ No				
Pancreatic	◯ Yes ◯ No				
Prostate	◯ Yes ◯ No				
Kidney (renal)	◯ Yes ◯ No				
Melanoma	◯ Yes ◯ No				
Other cancers among others, consider the following cancers: Brain, Kidney, Bladder, Small bowel, Sarcoma, Thyroid					
	◯ Yes ◯ No				
	◯ Yes ◯ No				

FAMILY HISTORY REVIEW (Wait to complete this with your healthcare provider - check all that apply)

Personal and/or family history of any one of the following:

- ☐ Two or more cancers on the same side of the family
- ☐ A personal or family history of cancer at age 60 or younger
- ☐ Any one or more of the following rare conditions:
  - Male breast cancer
  - 10 or more colorectal polyps
  - Triple negative breast cancer
  - Sarcoma
- ☐ Concerned about personal and/or family history of cancer
- ☐ Ashkenazi Jewish descent
- ☐ A family member that has had genetic testing for hereditary cancer risk

SIGNATURES

Patient's signature: _____ Date: _____

Provider's signature: _____ Date: _____

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Patient offered hereditary cancer genetic testing?	Appointment scheduled?	Date of next appointment
◯ Yes ◯ No ◯ Accepted ◯ Declined	◯ Yes ◯ No	