Assessment for Hereditary and Familial Cancer Risks

Patient Name: ____________________________________ Healthcare Provider Name: _______________________

Date of Birth: _____________________________________ Today's Date: _________________________________

This is a screening tool for cancer that runs in families. Please consider the following family members when completing the form:

1st Degree Relatives = Mother/Father/Sister/Brother/Children

2nd Degree Relatives = Aunt/Uncle/Grandparent/Grandchild/Niece/Nephew

3rd Degree Relatives = Cousin/Great-Grandparent/Great-Aunt/Great-Uncle

Have YOU or ANY OF YOUR RELATIVES been tested (BRCA/Colaris) for a Hereditary Cancer Syndrome? YES NO

Have YOU ever been Diagnosed with Cancer? What Type: Age:

		BREAST & OVARIAN CANCER (HBOC/BRAC*Analysis*)	Self	Siblings or Children	Your Relationship to Family Member		Age at Diagnosis	Living?
					Mother's Side	Father's Side		
Y	N	**Example: 2 or more Relatives with breast cancer; one before age 50**				**Aunt-breast** **Sister-breast**	**47 years** **60 years**	
Y	N	Have you or any family member had **Breast Cancer before Age 50**?						
Y	N	Have you or any family member had **Ovarian Cancer at Any Age**?						
Y	N	Have **2 Relatives** on Same Side of your family had Breast Cancer - **1 at Age 50 or Younger?**						
Y	N	Have **3 Relatives** on Same Side of your family had Breast Cancer at **Any Age**?						
Y	N	Has someone in your family had **Multiple Breast Cancers** (in the same OR both breasts)?						
Y	N	Have you or someone in your family had **Triple Negative** Breast Cancer?						
Y	N	Has any **Male** in your family had Breast Cancer **at Any Age**?						
Y	N	Are you of **Ashkenazi Jewish ancestry** with **family history of** Breast, Ovarian, or Pancreatic Cancer?						
Y	N	Do you have a family member with a known **BRCA mutation**?						

		COLON & UTERINE CANCER (Lynch Syndrome*/Colaris)	Self	Siblings or Children	Your Relationship to Family Member		Age at Diagnosis	Living?
					Mother's Side	Father's Side		
Y	N	Have you or any family member had Colon(Colorectal) or Uterine(Endometrial) Cancer **before Age 50**?						
Y	N	Do you have **2 or more** Relatives on the Same Side of the family with any of the following - **1 at age 50 or younger? (Circle):** ***Colon, Uterine,*** *Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*						
Y	N	Do you have **3 or more Relatives** on Same Side of the family with **any** of the following **at any age? (Circle)**: ***Colon, Uterine*** *, Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis, Pancreas*						
Y	N	Do you have a family member with a known **Lynch syndrome mutation**?						

For Office Use Only:

☐ Based on Personal & Family History, testing is not indicated for the patient at this time

☐ Genetic Testing Recommended for Patient: myRisk

☐ Patient Declined & Reason: _________________________________ Patient Signature: ______________________________

☐ Patient Accepted HCP Signature: _______________________________

*Lynch syndrome is caused by changes in specific genes and results in increased risk for Colon, Endometrial, Ovarian, Stomach and other cancers