Personal Information

Patient Name: _____ Date of Birth: _____Age: _____

Today's Date:_____ Health Care Provider:_____

Instructions: This is a screening tool for cancers that run in families. Please mark Y for those that apply to YOU and/or YOUR BIOLOGICAL FAMILY (on both your mother's/maternal or father's/paternal side). 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 family members should be considered:

- First-degree relatives: Mother, father, full siblings, or children
- Second-degree relatives: Grandparents, grandchildren, aunts, uncles, nephews, nieces or half-siblings
- Third degree relatives: First-cousins, great-grandparents or great grandchildren

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

	CANCER	YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER S SIDE	AGE
☐ Y ☐ N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt Cousin*	*45 61*	*Grandmother*	*53*
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	OTHER CANCER(S) (SPECIFY):							

☐ Y ☐ N Are you of Jewish descent?

PATIENT SIGNATURE:

Testing Criteria (office use only)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed under 50*
- ☐ Ovarian cancer at any age*
- ☐ Two primary breast cancers in the same person at any age*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- ☐ Male breast cancer
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**
- ☐ Metastatic prostate cancer*
- ☐ PERSONAL HISTORY METASTATIC BREAST CANCER (patient only)
- ☐ Pancreatic cancer*

Lynch Syndrome

- ☐ colon/rectal cancer or endometrial cancer diagnosed at or under age 50*
- ☐ A personal history of two or more Lynch syndrome cancers one being colon or endometrial cancer***
- ☐ Two or more relatives with a Lynch syndrome cancer***, one before the age of 50 and one being colon or endometrial cancer
- ☐ Three or more relatives with a Lynch syndrome cancer*** at any age and one being colon or endometrial cancer

☐ A previously identified BRCA1 or BRCA2 mutation, or Lynch syndrome mutation in the family

* In self, first or second degree family members

**HBOC associated cancer includes: *Breast, ovarian, and pancreatic cancer*

***Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.*

Cancer Risk Assessment Review and Counseling (office use only)

Health Care Provider's Signature: _____ Date: _____

Patient meets guidelines for genetic testing ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED Results Appt Date: _____

INFORMED REFUSAL: My provider has recommended hereditary cancer testing (myRisk testing) based on my personal and/or family history of cancer. He/She has explained to me the benefits of the genetic test and the risks of not consenting to the test. Despite my provider's recommendation, I decline to consent to the genetic test. **PATIENT SIGNATURE:_____**