RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES

Patient Name: ______________________ Provider Name: ______________________
Date of Birth: ______________________ Today's Date: ______________________
Reason for Today's Visit: ______________________ Insurance Company: ______________________

This is a screening tool for cancers that run in families. Please consider the following blood relatives:
Mother/Father/Sister/Brother/Children Aunt/Uncle/Niece/Nephew Grandparent

Have you or any of your relatives been tested for a hereditary cancer syndrome? YES ______ NO ________
Have YOU been diagnosed with cancer? What site (organ)? ____________________ What age? ________

		FAMILY HISTORY OF CANCER	SELF	WHICH FAMILY MEMBER (consider parents, children, siblings, aunts/uncles, nieces/nephews, and grandparents)	
				MOTHER'S SIDE	FATHER'S SIDE
(Y)	N	*EXAMPLE: Breast cancer* ***BEFORE AGE 50***	-----	-----------------	*Aunt, age 48*
Y	N	Ovarian cancer **AT ANY AGE**			
Y	N	Breast cancer **BEFORE AGE 50**			
Y	N	3 or more breast cancers on the same side of the family **AT ANY AGE**			
Y	N	Male breast cancer **AT ANY AGE**			
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer **AT ANY AGE**			
Y	N	**YOU** had colorectal or uterine (endometrial) cancer **BEFORE AGE 65**			
Y	N	2 colorectal or uterine (endometrial) cancers, **ONE BEFORE AGE 50**			
Y	N	3 or more colorectal or uterine (endometrial) cancers **AT ANY AGE**			
Y	N	You or a family member have **20 or more colon polyps** (in a lifetime)			
Y	N	Pancreatic cancer **AT ANY AGE**			

FOR OFFICE USE ONLY

- ☐ Patient meets criteria for genetic testing: ☐ YES ☐ NO
- ☐ Patient was offered genetic testing today: ☐ YES ☐ NO
- ☐ Patient **DECLINED** recommended genetic test: ☐ YES ☐ NO

Healthcare Provider Signature: ______________________

Patient signature if declining recommended testing: ______________________