FAMILY HISTORY QUESTIONNAIRE FOR HEREDITARY CANCER RISK

Personal Information

Patient Name		Gender (M or F)	
DOB		Today's Date	
Age		Physician Name	

Is Your Family of Jewish Descent? (circle) Yes No

Instructions

Please enter the **approximate age of diagnosis** for each individual family member that has/had cancer in the box under the appropriate cancer type column. **If exact age of diagnosis is unknown, please put a range (Ex: 20's, 30's, 40's)**

** Other Cancer" includes: Ureter/Renal Pelvis, Biliary Tract, Small Bowel, Brain, Sebaceous Adenoma, & 10 or more Gastrointestinal Polyps in Lifetime.

Family Member	Breast (Age)	Ovarian (Age)	Colon (Age)	Endometrial (Age)	Pancreatic (Age)	Melanoma (Age)	Gastric (Age)	Prostate (Age)	Other Cancer **See List Above** (Type and Age)
Yourself									
Your Brothers									
Your Sisters									
Your Sons									
Your Daughters									
Your Grandsons									
Your Granddaughters									
Your Nephews									
Your Nieces									
Mother's Side of Family (Maternal)									
Your Mother									
Your Aunts									
Your Uncles									
Your Cousins (M/F?)									
Grandmother/Gr Grndmthr									
Grandfather/Gr Grndfthr									
Father's Side of Family (Paternal)									
Your Father									
Your Aunts									
Your Uncles									
Your Cousins (M/F?)									
Grandmother/Gr Grndmthr									
Grandfather/Gr Grndfthr									

Patient Signature		Date	
Healthcare Provider Signature		Date	

Testing Recommended? (circle) Y N **Patient Accepts _____** **Patient Declines**