Risk Assessment for Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____
Date of Birth & Age: _____ Today's Date: _____
Insurance Type: _____ Time: _____

Instructions: This is to determine if you are at risk of a gene mutation that may cause cancer in you or family members. Please circle Y for those that apply to YOU and/or YOUR FAMILY - BOTH MOM & DADS SIDE OF THE FAMILY. Include any family members below:

Self Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather First Cousin

			YOU	*Which Family Member*	*Mom's side/Dad's side*	*Age at Diagnosis*
Y	N	Breast cancer	_____	_____	_____	_____
Y	N	Metastatic Breast cancer	_____	_____	_____	_____
Y	N	Breast cancer in both Breasts OR Breast cancer *twice* in the same person	_____	_____	_____	_____
Y	N	Ovarian cancer	_____	_____	_____	_____
Y	N	Male breast cancer	_____	_____	_____	_____
Y	N	Triple negative breast cancer Under age 60 (ER-, PR-, HER2- pathology)	_____	_____	_____	_____
Y	N	Pancreatic cancer	_____	_____	_____	_____
Y	N	Ashkenazi Jewish ancestry				
Y	N	Uterine/Endometrial cancer	_____	_____	_____	_____
Y	N	Colon/Colorectal cancer	_____	_____	_____	_____
Y	N	10+ Colon polyps (lifetime)	_____	_____	_____	_____
Y	N	Stomach/Bladder cancer	_____	_____	_____	_____

Y N Have you or any member of your family ever been tested for hereditary risk of cancer?

If yes, please explain: _____

_____
Patient's Signature Date

*For a better understanding of triple negative breast cancer please ask your healthcare provider.