



West Coast Obstetrics & Gynecology Associates • 7910 Frost Street, Suite 400 • San Diego, CA 92123

**Personal/Family History Questionnaire for Common Hereditary Cancer Syndromes**

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructions:** Please circle Y to those that apply to **YOU and/or YOUR FAMILY** (on both your **mother's or father's side**). Next to each statement, please list the **relationship to you** of the individual diagnosed (such as self, paternal aunt, maternal uncle, paternal grandmother) and their **age of diagnosis**. Answer each statement individually - you may list the same cancer diagnosis more than once as you answer each question. This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y to any of the statements below, you **MAY** be appropriate for genetic testing. Ask your healthcare provider for additional information.

**BREAST AND OVARIAN CANCER:**

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50		
Y	N	Ovarian cancer		
Y	N	Breast cancer in both breasts or multiple primary breast cancers		
Y	N	Both breast and ovarian cancer in an individual OR a family		
Y	N	Male breast cancer		
Y	N	2 or more breast or ovarian cancers in an individual OR family		
Y	N	Ashkenazi Jewish ancestry and a personal or family history of breast or ovarian cancer		

**COLON AND UTERINE CANCER:**

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50		
Y	N	Colon cancer before age 50		
Y	N	Both uterine and colon cancer in an individual OR a family		
Y	N	2 or more uterine or colon cancers in an individual OR family		
Y	N	Uterine AND/OR colon cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer in an individual or family		
Y	N	10 or more colon polyps found in a lifetime		

**MELANOMA:**

			RELATIONSHIP	AGE AT DIAGNOSIS
Y	N	2 or more melanomas in an individual or family		
Y	N	Both melanoma and pancreatic cancer in an individual or family		

**FOR THE HEALTHCARE PROVIDER:**

Candidate for further risk assessment and/or genetic testing Information given to patient to review Follow up appointment scheduled: _____ Patient offered genetic testing: <b>ACCEPTED</b> <b>DECLINED</b>
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Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Health Care Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_