West Coast Obstetrics & Gynecology Associates • 7695 Cardinal Court, Suite 240 • 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: ___**ACCEPTED** ___ **DECLINED**

Patient's Signature:_____ Date: _____ Health Care Provider's Signature: _____ Date: _____

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