

Hereditary Cancer Risk Assessment Questionnaire – General Instructions

Please answer the following questions about your personal and family history to the best of your knowledge. This will help your provider understand if there could be patterns of hereditary cancer in your family. For personal history, enter the types of cancer you have had and your age at diagnosis. For family members who are blood relatives, enter the types of cancer they had and their approximate age at diagnosis. Family members include parents, siblings, children, uncles, aunts, grandparents, great-grandparents, grandchildren, great-grandchildren, great-uncles, great-aunts, nieces, nephews, or half-sibling.

Family History of Cancer

Type of Cancer	Personal / Family History	Personal – age at diagnosis	Parent/sibling/child - list age at diagnosis	Family members on mother's side – list sex and age at diagnosis	Family members on father's side – list sex and age at diagnosis
Example: Breast Cancer	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	40	Mom, F, 47 Sister, F, 55	Aunt, F, 50	Niece, F, 36
Breast	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Ovarian	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Pancreatic	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Colorectal	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Uterine	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Gastric	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Melanoma	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other (please fill in):	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Other (please fill in):	<input type="checkbox"/> Yes <input type="checkbox"/> No				

Please complete the following check all that apply:

- Personal or family history of cancer at age 50 or younger
- Personal or family history of ovarian or pancreatic cancer
- Personal or family history of one or more of the following conditions: Male Breast Cancer / Triple Negative Breast cancer / 10 or more colorectal polyps
- Two relatives with cancer on the same side of your family
- Ashkenazi Jewish descent
- You have had hereditary cancer genetic testing (if yes, please attach the report to the Empower Requisition Form)
- Family member that has had hereditary cancer genetic testing. If yes, list gene mutation found; if any _____
- Concerned about personal and/or family history of cancer

Signature

For office use only

Patient's Name Patient Signature Date

Patient offered hereditary cancer testing (check all that apply)

- Yes No Patient accepted Patient declined

Provider's Name Provider's Signature Date