

Risk Assessment for Hereditary Cancer Syndrome

Patient Name: _____ Date of Birth: _____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the family member's relationship to you, the site of their cancer and their age when they were diagnosed with cancer.

1st Degree Relatives- Mother/Father/Sister/Brother/Children
2nd Degree Relatives- Aunt/Uncle/Grandparent/Niece/Nephew

Have you ever been diagnosed with cancer? What site: __ What age: _____?

COLON AND UTERINE CANCER (COLARIS)			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
Y	N			MOTHER'S SIDE (alive/deceased?)	FATHER'S SIDE (alive/deceased?)	
		Endometrial (Uterine) cancer before age 50				
		Colorectal cancer before age 50				
		Two or more of the following cancers on the same side of the family: colon, uterine (endometrial), ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
		20 or more lifetime colorectal polyps				
		A family member with a known Lynch Syndrome mutation				
BREAST AND OVARIAN CANCER (BRACAnalysis)			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
Y	N			MOTHER'S SIDE (alive/deceased?)	FATHER'S SIDE (alive/deceased?)	
		Breast cancer at age 45 or younger (in self, first or second degree family members)				
		Bilateral breast cancer in a first degree relative regardless of age (in self, first or second degree family members)				
		Ovarian cancer at any age (in ANY family members)				
		Two relatives on the same side of the family with breast cancer, 1 under the age of 50				
		Three relatives on the same side of the family with breast and/or ovarian cancer at any age				
		Hormone negative breast cancer under the age of 60 (receptor status negative for ER, PR and HER2)				
		Male breast cancer at any age				
		Pancreatic cancer or Prostate cancer with 2 or more Breast and/or Ovarian cancers on the same side of the family				
		A family member with a known BRCA mutation				

Are you of Jewish descent? YES NO

Is there any other cancer in you or any family members not listed above?

Patient's signature: _____

Today's Date: _____

FOR OFFICE USE ONLY

- Patient offered genetic testing:
- Accepted
- Declined
- Patient is not appropriate for further risk assessment at this time.

HCP Signature: _____