Hereditary Cancer Risk Assessment

Name_____ **Address, City, Zip**_____ **DOB**_____ **Age**____

Daytime Phone Number_____ **Are you of Ashkenazi Jewish Decent?** ◯ **No** ◯ **Yes**

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ◯ **No** ◯ **Yes Results**_____

Height_____ Weight_____ Age of First Period_____ Age when you had first child (If applicable)_____

Age of Menopause (if applicable)_____ Have you ever used Hormone Replacement Therapy? ◯ No ◯ Yes

Instructions: This is a screening tool for cancers that run in families. Please answer as completely as possible.

Do **You** have a personal history of cancer? ◯ No ◯ Yes If "Yes" please complete table below

Personal History Your History of Cancer	Age Of Diagnosis	Maternal or Paternal	Breast	Ovarian	Endometrial/Uterine	Colon	Pancreatic
Example Yes	35		x				

Do you have FAMILY MEMBERS with a history of cancer? ◯ **No** ◯ **Yes If Yes, please complete this table below,** If specific ages are unknown, estimate the age (50's, 60's) or <(less than) 50 or >(great than) 50

1st Degree Relatives = Mother / Father / Sister / Brother / Children

2nd Degree Relatives = Aunt / Uncles / Grandparent / Niece / Nephew

Family Member (List specific relative Maternal and Paternal)	Age of Diagnosis	Maternal or Paternal	**Breast Cancer** in your family **before age 50**	**Ovarian Cancer** in your family at any age	**Colon Cancer** in your family **before age 50**	**Uterine or Endometrial Cancer** in your family **before age 50**	**Ashkenazi Jewish Ancestry** with **Breast or Pancreatic cancer** at any age	**Pancreatic Cancer** at any age	**Male Breast Cancer** in your family at any age	**THREE OR MORE** relatives on one side of your family with **Breast or Prostate** cancer at any age	**Bilateral Breast Cancer** in your family at any age
Example Aunt	34	M		X							

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Education? ◯ Yes ◯ No ◯ More information needed

IF YES, Patient chose to: ◯ **ACCEPT** ◯ **DECLINE High Risk Education**: Reason _____

If ACCEPTED, Patient: ◯ **SUBMITTED MyRisk** ◯ **DECLINED Testing**: Reason_____

Patient Signature: _____ Date: _____

Provider Signature: _____