Mercy Clinic Women's Health

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Family History Questionnaire

Name: ______________________________ Date: ______________

Instructions: Please circle **Y** to those that apply to YOU and/or YOUR FAMILY *(on both your mother and father's side).* Behind each statement, please list relationship to you of the diagnosed *(example: self, maternal aunt, sister, paternal cousin)* and their age at diagnosis.

HEREDITARY BREAST AND OVARIAN CANCER SYNDROME

Personal History			*Relationship*	*Age at Diagnosis*
Y	N	Personal history of breast cancer before age 50	________	____
Y	N	Personal history of ovarian cancer at ANY age	________	____
Y	N	Breast cancer in both breasts at any age	________	____
Family History				
Y	N	Breast cancer in both breasts in a family member *(at any age)*	________	____
Y	N	Both breast & ovarian cancer (at any age)	________	____
Y	N	Male breast cancer *(at any age)*	________	____
Y	N	Two or more breast or ovarian cancers *(on one side of family or in an individual)*	________	____
Y	N	Ashkenazi Jews with personal history or family history of breast or ovarian cancer *(at any age)*	________	____

HEREDITARY NONPOLYPOSIS COLORECTAL CANCER SYNDROME

Y	N	Personal history of cancer of the uterus before age 50	________	____
Y	N	Personal history of colon or rectal cancer before age 50	________	____
Y	N	Personal history of colon or rectal or cancer or cancer of the uterus after 50 & family member with any of the following cancers:	________	____

(PLEASE circle those that apply)
Colon Rectal Uterine Stomach Ovarian Biliary tract Small bowel
Pancreas Kidney (ureter/renal pelvis) Brain Sebaceous adenoma

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If you circled YES to one or more statements on the Family History Questionnaire, you may be a candidate for counseling and may be appropriate for a blood test to help determine if you have an inherited risk of cancer.

______ Patient offered risk counseling: ☐ Accepted ☐ Decline ☐ Undecided