Hereditary Cancer Risk Assessment Form

Patient Name:_____ **Date of Birth:**_____ **Your Provider:**_____ **Date of Visit:**_____

INSTRUCTIONS: **Please circle YES** to any statement below if it applies to **YOU or YOUR FAMILY MEMBERS**.
Next to each statement, please list the **AGE** of the person when they were **DIAGNOSED** with cancer and your relation.

Please include all family members on both your MOTHER'S and FATHER'S sides:

	BREAST AND OVARIAN CANCER	You or Siblings	AGE	Mother's Side	AGE	Father's Side	AGE
Y / N	Where you diagnosed with breast cancer BEFORE age 50						
Y / N	Ovarian Cancer at ANY age						
Y / N	TWO or more breast cancers on the same side of the family, 1 UNDER age 50						
Y / N	THREE or more breast cancers on the same side of the family, at ANY age						
Y / N	Multiple breast cancers in the same person (in the same breast or in both breasts)						
Y / N	Male Breast Cancer						
Y / N	Triple Negative Breast Cancer						
Y / N	Pancreatic cancer with breast or ovarian cancer on the same side of the family						
Y / N	Ashkenazi Jewish ancestry with ANY breast cancer in the family.						
Y / N	BRCA Mutation in the family						
	COLON AND UTERINE CANCER	**You or Siblings**	**AGE**	**Mother's Side**	**AGE**	**Father's Side**	**AGE**
Y / N	Have YOU had Uterine (Endometrial) or Colorectal cancer BEFORE age 50						
Y / N	TWO or more colon cancers or uterine cancers on the same side of the family, 1 UNDER age 50.						
Y / N	THREE or more colon cancers or uterine cancers on the same side of the family at ANY age						

FOR OFFICE USE ONLY:

Did patient meet criteria for Genetic Testing? ☐ YES ☐ NO ☐ MORE INFORMATION NEEDED

If YES, Patient chose to: ☐ ACCEPT ☐ DECLINE

If MORE INFORMATION NEEDED, Follow-up appointment scheduled: Date:_____

PATIENT SIGNATURE for declined testing:_____ **Date:**_____

Provider's Signature:_____ **Date:**_____