Cancer Risk Assessment Form

Patient Name ____________________ Date of Birth ____/____/____ Date Completed ____/____/____

This is a screening tool for the common features of hereditary cancer. Our service will allow us to give you the most technologically advanced screening possible to increase the chances of cancer detection and early intervention to optimize your health.

Circle Y for those that apply to YOU and/or YOUR FAMILY (consider all relatives on both mother's and father's side). YOU AND THE FOLLOWING CLOSE BLOOD RELATIVES SHOULD BE CONSIDERED. ***Mother, Father, Sister, Brother, Sons, Daughters, Half-Siblings, Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins, Great Grandparents, Great Aunt/Uncle***

TYPES OF CANCER			RELATIONSHIP TO FAMILY MEMBER with CANCER and AGE at DIAGNOSIS		
			SELF/ SIBLING	**MOTHER or Relatives on MOTHERS's side**	**FATHER or Relatives on FATHER's side**
		EXAMPLE:	Me 35 Sister 40	Aunt 35	Grandmother 75
Y	N	Breast cancer **before** age 50?			
Y	N	Multiple breast cancers on the **same side** of the family? • If 2 breast cancers, one must be **at or before** age 50 • If 3+ breast cancers, they can be at **any age**			
Y	N	Ovarian cancer **at any age**?			
Y	N	Male breast cancer **at any age**?			
Y	N	Pancreatic cancer **at any age**?			
Y	N	Metastatic prostate cancer **at any age**?			
Y	N	Ashkenazi Jewish ancestry ***with*** breast, ovarian, or pancreatic cancer **at any age**?			
Y	N	Colon Cancer **before** age 50?			
Y	N	Endometrial Cancer **before** age 50?			
Y	N	Colon **and/or** Endometrial Cancer at any age AND two or more of the following cancers in the same person or on the same side of the family **at any age**? *(ovarian, stomach, renal pelvis, small bowel, pancreas, brain)*			
Y	N	**Ten or more** lifetime colon polyps?			
Y	N	Any other cancers?			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No ☐ Do Not Know

Patient signature: ____________________ Date: ____________________

For Office Use Only:

Patient offered testing ☐ Accepted ☐ Declined Reason for decline: ☐

☐ Does Not Meet Criteria ☐ Sample Collected

Physician Signature____________________