

Hereditary Cancer Syndrome Risk Assessment

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

This is a screening tool for the common features of Hereditary Breast and Ovarian Cancer Syndrome and Lynch Syndrome.

Instruction:

- Please circle **Y** for those that apply to **YOU and/or YOUR FAMILY** (on both your mothers or fathers side).
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family member should be considered:

Mother, Father, Brother, Sister, Children, Nieces/Nephews
Maternal – Grandmother, Grandfather, Aunts, Uncles, First Cousins
Paternal - Grandmother, Grandfather, Aunts, Uncles, First Cousins

Y	N	Have you ever been tested for hereditary risk of cancer (BRCA testing or Lynch Syndrome Testing)? If yes, please explain:
Y	N	Have any members of your family ever been tested for hereditary risk of cancer (BRCA testing or Lynch Syndrome Testing)? If yes, please explain:

BREAST AND OVARIAN CANCER		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Ashkenazi Jewish ancestry with breast or ovarian cancer diagnosed in you or any family member?		
Y	N	Ovarian cancer diagnosed in you or any family members?		
Y	N	Male breast cancer diagnosed in any family members?		
Y	N	Breast cancer diagnosed at 45 years of age or younger in you or any family members?		
Y	N	Bilateral breast cancer or multiple primary breast cancers diagnosed in you or any family members?		
Y	N	Three or more breast cancers diagnosed all on the same side of your family?		
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family?		
COLON AND UTERINE CANCER		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Colon cancer diagnosed before 50 years of age in you or any family members?		
Y	N	Uterine (Endometrial) cancer diagnosed before 50 years of age in you or any family members?		
Y	N	Two or more of the following cancers diagnosed all on the same side of your family (colon, uterine, ovarian, stomach, small Bowel, kidney/urinary tract, pancreatic, or brain)		

For Office Use Only	
Patient offered genetic testing	
<input type="checkbox"/> Accepted <input type="checkbox"/> Declined	Reviewed By: _____

Patient Signature _____