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Family History Questionnaire For Cancer Risk

Patient Name: ______________________ Today's Date: ______________

Physician Name: ______________________ Date of Birth: ______________

Is your family of Ashkenazi Jewish descent? ☐ Yes ☐ No ☐ Unknown

Please enter the **AGE OF CANCER DIAGNOSIS** in the boxes below for yourself **AND** for each family member who has been diagnosed with cancer:

	Breast Cancer	Ovarian Cancer	Colorectal Cancer	Endometrial (Uterine) Cancer	Other Cancers
Yourself					
Your Brothers					
Your Sisters					
Your Children					
MOTHER'S SIDE OF THE FAMILY					
Your Mother					
Your Aunts					
Your Uncles					
Your Cousins					
Grandparents					
FATHER'S SIDE OF THE FAMILY					
Your Father					
Your Aunts					
Your Uncles					
Your Cousins					
Grandparents					

Candidate for further risk assessment and/or genetic testing ☐ Yes ☐ No

Patient recommended genetic testing ☐ Accepted ☐ Declined

Your typed name constitutes an electronic signature, and acknowledges the information provided is correct and the terms agreeable to you.

Patient's Signature ______________________ Date ______________

Health Care Provider's Signature ______________________ Date ______________