Cancer Risk Assessment

_____ _____/_____/_____ _____/_____/_____

Patient Name Date of Birth Date Completed

This is a screening tool for the common features of hereditary cancer. Please answer these questions and take into consideration all the family members listed. 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

		CANCER		RELATIONSHIP TO FAMILY MEMBER w/ CANCER	
			SELF, SIBLINGS, CHILDREN	Mother or Relatives on Mother's side (Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins)	FATHER or Relatives on FATHER's side (Aunts, Uncles, Grandparents, Nieces, Nephews, Cousins)
PLEASE ANSWER EACH QUESTION, LIST WHICH FAMILY MEMBER HAD THE CANCER AND THEIR AGE OF DIAGNOSIS					
Y	N	Breast Cancer **before** age 50?			
Y	N	Multiple breast cancers on the **same side** of the family? • If two breast cancers one must be before **age 50** • If three or more breast cancers they can be at any age			
Y	N	Ashkenazi Jewish ancestry with a breast cancer in any family member at **any age**?			
Y	N	Male breast cancer at **any age**?			
Y	N	Ovarian cancer at **any age**?			
Y	N	Endometrial (Uterine) Cancer **before** age 50?			
Y	N	Colon Cancer **before** age 50?			
Y	N	**Ten or more** lifetime colon polyps (colorectal adenomas)?			
Y	N	Three or more Colon **and/or** Endometrial Cancer at any age			
Y	N	Other Cancers?			

Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? ☐ Yes ☐ No

Patient signature: _____ **Date:** _____

If you "opted out" of filling this form out please sign and date the above line, acknowledging you were offered screening

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For Office Use Only:

Patient offered risk assessment ☐ Accepted ☐ Declined Reason for Decline: _____

Provider Signature_____ Date:_____