Family History Tool

Hope Abounds CANCER NETWORK

Purpose: This tool screens for hereditary cancer syndromes, and can determine if you may be appropriate for hereditary cancer testing

Instructions: *Check any YES circle below if you or any of your 1st, 2nd or 3rd relatives have been diagnosed. If ages is unknown, mark with question symbol.*

1st Degree Relatives = Mother/Father/Sister/Brother/Children
2nd Degree Relatives = Aunt/Uncle/Grandparent/Niece/Nephew
3rd Degree Relatives = Cousin/Great Grandparent

YES

○ Have you or any of your relatives been tested for hereditary cancer (HBOC or Lynch Syndrome?)

○ Have you ever been diagnosed with any type of cancer?
If yes, when? _____ At what age were you diagnosed? _____

YES		SELF	1st DEGREE	2nd DEGREE	3rd DEGREE	AGE AT DIAGNOSIS
○	Breast Cancer at age 50 or younger	○	○	○	○	_____
○	Ovarian Cancer	○	○	○	○	_____
○	Male Breast Cancer	○	○	○	○	_____
○	Triple Negative Breast Cancer (ER-, PR-, HER2 pathology)	○	○	○	○	_____
○	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family	○	○	○	○	_____
○	Ashkenazi Jewish descent with breast, ovarian or pancreatic cancer in the same person or on the same side of family	○	○	○	○	_____
○	Uterine (endometrial) cancer before age 50	○	○	○	○	_____
○	Colon Cancer before age 50	○	○	○	○	_____

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Hope Unleashed.
Lives Transformed.

YES		MOTHER	FATHER	AGE AT DIAGNOSIS
◯	Please check YES if you have two or more (at any age) of the following cancers on the same side of the family: colon, uterine (endometrial), ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis, glioblastoma. Indicate if the cancers are from your Mother or Father, and their aged when diagnosed. If ages is unknown, mark with question symbol.	◯	◯	_____
◯	A family member with a known Lynch Syndrome mutation	◯	◯	_____
◯	Is there any other cancer in you or any family members not listed above? If yes, please provide addt'l information - family members relationship to you, the kind/site of their cancer & their age when they were diagnosed.			_____

_____

Patient or Representative Signature: _____ Date: _____

If signed by someone other than the patient, please specify relationship to the patient. _____

FOR OFFICE USE ONLY

Patient appropriate for further risk assessment and/or genetic testing:

◯ HBOC ◯ Lynch

◯ Information Given to Patient
◯ Follow Up Appointment Scheduled
◯ Patient Offered Genetic Testing
◯ Accepted Declined

Physician's Signature: _____

Date: _____

Medical Facility affiliation: _____