Hereditary Cancer Questionnaire

Name: _____ Date of Birth: _____

Today's Date: _____

Instructions: This is a screening tool for cancers that run in families. Next to each **blood-related** family member, please list any cancer(s) they have been diagnosed with and their age of diagnosis (if known). If you do not know the exact age of diagnosis, you can put an estimate, ex. 50s or 80s.

Examples of cancer types to consider: bladder, breast, colon/rectal, kidney, leukemia, lymphoma, ovarian, pancreatic, prostate, testicular, uterine, brain, liver, lung, melanoma, penile, sarcoma, skin, small bowel, stomach, thyroid

Be as thorough as possible

❑ Please check if you do not know your blood-related family history (Ex. I'm adopted)

Relationship	Sex	Cancer Type(s)	Age(s) at Diagnosis
Child 1	M❑ F❑		
Child 2	M❑ F❑		
Child 3	M❑ F❑		
Sibling 1	M❑ F❑		
Sibling 2	M❑ F❑		
Sibling 3	M❑ F❑		
Mother's Side			
Relationship	**Sex**	**Cancer Type(s)**	**Age(s) at Diagnosis**
Mother	M❑ F❑		
Grandmother	M❑ F❑		
Grandfather	M❑ F❑		
Aunt/Uncle 1	M❑ F❑		
Aunt/Uncle 2	M❑ F❑		
Aunt/Uncle 3	M❑ F❑		
Father's Side			
Relationship	**Sex**	**Cancer Type(s)**	**Age(s) at Diagnosis**
Father	M❑ F❑		
Grandmother	M❑ F❑		
Grandfather	M❑ F❑		
Aunt/Uncle 1	M❑ F❑		
Aunt/Uncle 2	M❑ F❑		
Aunt/Uncle 3	M❑ F❑		

Are you of Ashkenazi Jewish descent? ❑ Yes ❑ No

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

_____ _____

Clinician's Printed Name Clinician's Signature