For office use only

Patient offered genetic testing
❒ Accepted ❒Declined

Reviewed by:_____

OPTIONAL

Hereditary Cancer Syndrome Risk Assessment

Patient Name: _____ Physician: _____

Date of Birth: _____ Today's Date: _____

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

Instructions:

- Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's or father's side.)
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family members 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 members?			
Y	N	Ovarian cancer diagnosed in your or any family members?			
Y	N	Male breast cancer diagnosed at 45 years of age or younger in you or any family members			
Y	N	Breast cancer diagnosed at 45 years if age or younger in you or any family members?			
Y	N	Bilateral breast cancer or multiple primary breast cancers diagnosed in your 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			
Y	N	Colon cancer diagnose before 50 years of age in you or any family members?			
Y	N	Uterine (endometrial) cancer diagnose before 50 years of age In your or any family members?			
Y	N	Two or more of the following cancers diagnosed all on the same side your family (colon, uterine, ovarian, stomach, small bowel, Kidney/urinary tract, pancreatic or brain)			

X_____

Patient Signature