



**Genetic Risk Evaluation And Testing Program
Hereditary Cancer Risk Assessment Form**

Patient Name (print): _____ **DOB:** _____ **Phone (Day):** _____

Most cancer happens by chance and is not passed through families. However, in some families, cancer may be due to specific genetic factors that can be passed from parent to child. Identifying these hereditary families can help to determine the risk of cancer for individuals and their relatives. Individuals at hereditary risk for cancer have medical options to increase the chances of finding cancer early and reduce the risk of a first or second cancer. A careful review of the family history is an essential first step in identifying high-risk families. Please complete the family history check list below:

If you have or had cancer, what type(s): _____ **Age Diagnosed:** _____

<i>Please check the boxes below. Please include only blood relatives and consider your mother and father's side of the family separately.</i>			
Is there a Personal or Family History of:	Have YOU had:	Do you have a family history of:	Please list the relative(s) and the type of cancer (Ex: mom - breast & maternal aunt - ovarian)
Breast cancer at or before age 45?	<input type="checkbox"/>	<input type="checkbox"/>	
Triple Negative Breast Cancer at or before age 60? (ER/PR/HER2 negative cancer)	<input type="checkbox"/>	<input type="checkbox"/>	
Two primary breast cancers in the same person with one at or before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	
2 relatives on the same side of the family with breast cancer with one diagnosed at or before age 50? (you may count yourself)	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian Cancer at any age?	<input type="checkbox"/>	<input type="checkbox"/>	
Breast & Ovarian cancer in the same person?	<input type="checkbox"/>	<input type="checkbox"/>	
Male Breast Cancer at any age?	<input type="checkbox"/>	<input type="checkbox"/>	
3 or more relatives with breast, ovarian, pancreatic and/or aggressive prostate cancer on the same side of the family at any age (you may count yourself)?	<input type="checkbox"/>	<input type="checkbox"/>	
Colon Cancer before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	
Uterine Cancer before age 50?	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal MSI or IHC tumor test results? (testing done on colon or uterine tumors)	<input type="checkbox"/>	<input type="checkbox"/>	
2 or more of the following cancers in the same person OR 2 or more relatives on the same side of the family with one of the following cancers: colon, uterine, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas? (you may count yourself)	<input type="checkbox"/>	<input type="checkbox"/>	
10 or more polyps in the colon?	<input type="checkbox"/>	<input type="checkbox"/>	
2 or more Melanomas in the same person?	<input type="checkbox"/>	<input type="checkbox"/>	
Melanoma and pancreatic cancer in the same person?	<input type="checkbox"/>	<input type="checkbox"/>	
3 or more relatives with melanoma and/or pancreatic cancer at any age on the same side of family (you may count yourself)?	<input type="checkbox"/>	<input type="checkbox"/>	
A known mutation (gene change) in a cancer gene?	<input type="checkbox"/>	<input type="checkbox"/>	
Ashkenazi (Central/Eastern European) Jewish Ancestry and a personal or family history of breast, ovarian or pancreatic cancer?	No: <input type="checkbox"/> Yes: <input type="checkbox"/> Maternal <input type="checkbox"/> Paternal <input type="checkbox"/> Both Sides		
Do you have any other concerns about your personal or family history of cancer?	If yes please describe:		

If any of the boxes are checked YES, you are a candidate for the Genetic Risk Evaluation and Testing Program. Please discuss with your physician.

Patient Signature

Date

Health Care Provider

Date