Hereditary Cancer Syndrome Risk Assessment

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

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

Instruction:

- Please circle **Y** for those that apply to **YOU and/or YOUR FAMILY** (on both your mothers or fathers side).
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family member 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 member?**			
Y	N	**Ovarian cancer diagnosed in you or any family members?**			
Y	N	**Male breast cancer diagnosed in any family members?**			
Y	N	**Breast cancer diagnosed at 45 years of age or younger in you or any family members?**			
Y	N	**Bilateral breast cancer or multiple primary breast cancers diagnosed in you 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	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y	N	**Colon cancer diagnosed before 50 years of age in you or any family members?**			
Y	N	**Uterine (Endometrial) cancer diagnosed before 50 years of age in you or any family members?**			
Y	N	**Two or more of the following cancers diagnosed all on the same side of your family**(colon, uterine, ovarian, stomach, small Bowel, kidney/urinary tract, pancreatic, or brain)			

For Office Use Only

Patient offered genetic testing

☐ Accepted ☐ Declined Reviewed By: _____

Patient Signature _____