HEREDITARY CANCER RISK ASSESSMENT

Patient Name: _____ **Today's Date:** _____

Your Physician: _____ **Date of Birth:** _____

INSTRUCTIONS: Please circle YES (Y) to any statement below if it applies to YOU or YOUR FAMILY MEMBERS.
Next to each statement, please list the AGE of the person when they were DIAGNOSED with cancer and your relation.
1st Degree Relatives = Mother / Father / Sister / Brother / Children
2nd Degree Relatives = Aunt / Uncle / Grandparent / Niece / Nephew
AND 3rd Degree Relatives = Great Grandparents / 1st Cousins

1. Have YOU had Genetic Testing for Hereditary Cancer, Previously (BRCA/MyRisk)?

□ **YES**	Approximate year you were tested _____ **Result:** □ Positive □ Negative □ Unknown
□ **No**	Proceed to Section 2 - Cancer Family History

2. Yes/No		**CANCER FAMILY HISTORY**	**YOU SIBLINGS CHILDREN**	**MOTHER'S SIDE**	**FATHER'S SIDE**	**Age at Diagnosis**
Y	N	Have **YOU** ever had **Breast Cancer** at any age				
Y	N	**Ovarian Cancer** in your family at any age				
Y	N	**Breast Cancer** in your family **before age 50**				
Y	N	**Bilateral Breast Cancer** in your family at any age				
Y	N	**THREE OR MORE** relatives on one side of your famiy with **Breast or Prostate Cancer** at any age				
Y	N	**Male Breast Cancer** in your family at any age				
Y	N	**Pancreatic Cancer** in your family at any age				
Y	N	**Ashkenazi Jewish Ancesetry** with **Breast or Pancreatic Cancer** in your family at any age				
Y	N	**Colon Cancer** in your family **before age 50**				
Y	N	**Uterine Or Endometrial Cancer** in your family **before age 50**				
Y	N	**THREE OR MORE** relatives on one side of your family with **Colon/Rectal, Uterine/Endometrial, or Gastric/Stomach Cancer** at any age				
Y	N	Have **YOU** ever had **Uterine or Endometrial Cancer**				

FOR OFFICE USE ONLY:
Did Patient meet criteria for Genetic Education? □ **YES** □ **NO** □ **MORE INFORMATION NEEDED**
If Yes, Patient chose to: □ **ACCEPT** □ **DECLINE High Risk Education:** Reason: _____
If ACCEPTED, Patient: □ **SUBMITTED myRisk** □ **DECLINED Testing:** Reason: _____

PATIENT SIGNATURE: _____ Date: _____

PROVIDER SIGNATURE: _____