Date:_____

OAKLAND MACOMB

OBSTETRICS & GYNECOLOGY, P.C.

Hereditary Cancer Risk Assessment Questionnaire

Patient Name: _____ DOB:_____

The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on BOTH sides of the family.

Do you have a **personal** history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or **pancreatic** cancer at any age	Y N		
Colorectal or **uterine** cancer at 64 or younger	Y N		

Do you have a **family** history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side?	Age at diagnosis?
Breast cancer at 49 or younger	Y N		M P	
Two breast cancers (bilateral) in one relative at any age	Y N		M P	
Three breast cancers in relatives on the same side of the family at any age	Y N		M P	
Ovarian cancer at any age	Y N		M P	
Pancreatic cancer at any age	Y N		M P	
Male breast cancer at any age	Y N		M P	
Metastatic prostate cancer at any age *(Spread beyond prostate)*	Y N		M P	
Colon cancer at 49 or younger	Y N		M P	
Uterine cancer at 49 or younger	Y N		M P	
Ashkenazi Jewish ancestry with breast cancer at any age	Y N		M P	
Do you have a family history of other cancers?	Y N	List them here:		
Have you or anyone in your family had genetic testing for hereditary cancer?	Y N	Who?	What gene(s)?	What was the result?

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Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No

If yes, ☐ Patient accepted ☐ Patient declined

Patient signature _____ Date: _____

Healthcare Provider signature_____ Date: _____