

# HEREDITARY CANCER RISK ASSESSMENT QUESTIONNAIRE

PATIENT INFO

Name DOB Date

The information provided below will help to evaluate your risk for hereditary cancer. If genetic counseling is appropriate, you will be referred to the Genetic Counseling/Hereditary Cancer Risk Assessment Program.

Please place a check mark in the boxes below for yourself and family members who have had cancer.

**BREAST CANCER**

Yourself  
 Sister(s)/Brother(s)  
 Daughter(s)/Son(s)  
 Niece(s)/Nephew(s)

**Mother's Side**

Mother  
 Grandmother  
 Grandfather  
 Aunt(s)/Uncle(s)  
 Cousin(s)  
 Other

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**Father's Side**

Father  
 Grandmother  
 Grandfather  
 Aunt(s)/Uncle(s)  
 Cousin(s)  
 Other

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Anyone with breast cancer diagnosed before age 50

**OVARIAN CANCER**

Yourself  
 Sister(s)  
 Daughter(s)  
 Niece(s)

**Mother's Side**

Mother  
 Grandmother  
 Aunt(s)  
 Cousin(s)  
 Other

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**Father's Side**

Grandmother  
 Aunt(s)  
 Cousin(s)  
 Other

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Any peritoneal cancer or fallopian tube cancer

**COLON CANCER**

Yourself  
 Sister(s)/Brother(s)  
 Daughter(s)/Son(s)  
 Niece(s)/Nephew(s)

**Mother's Side**

Mother  
 Grandmother  
 Grandfather  
 Aunt(s)/Uncle(s)  
 Cousin(s)  
 Other

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**Father's Side**

Father  
 Grandmother  
 Grandfather  
 Aunt(s)/Uncle(s)  
 Cousin(s)  
 Other

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Any colon cancer diagnosed before age 50

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PATIENT INFO

Are you Ashkenazi Jewish?    Yes    No    Uncertain

Have you or anyone in your family had genetic testing?    Yes    No    Uncertain

If yes, please indicate who, what test and the result:

**Please check if you have had:**

Prostate Cancer (needed treatment)    Melanoma    Thyroid Cancer  
Pancreatic Cancer    Cancer of the Uterus    More than 10 colon polyps  
Other, not listed, please specify:

**Please check if any family members have had:**

Prostate Cancer (needed treatment)    Melanoma    Thyroid Cancer  
Pancreatic Cancer    Cancer of the Uterus    More than 10 colon polyps  
Other, not listed, please specify: