Screening: Your Personal and Family History of Cancer

Patient Name:_____ Date of Birth: _____

If you have a **personal or family history** of the following cancers, please indicate **WHO** and **AGE at diagnosis**. Include parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, great aunts/uncles, great grandparents and cousins.

| | | | You (age of diagnosis) | Siblings/Children (age of diagnosis) | Mother's Side (age of diagnosis) | Father's Side (age of diagnosis) |
|---|---|---|---|---|---|---|
| Y | N | EXAMPLE: *Breast Cancer* | | | *Aunt 53* | *Grandmother 45* |
| Y | N | Breast Cancer | | | | |
| Y | N | Ovarian Cancer *(Peritoneal/Fallopian Tube)* | | | | |
| Y | N | Are you of Ashkenazi Jewish Descent? | | | | |
| Y | N | Colon / Rectal cancer | | | | |
| Y | N | Endometrial (uterine) cancer | | | | |
| Y | N | 10 or more colon polyps in a lifetime (specify #) | | | | |
| Y | N | Prostate Cancer (HBOC) | | | | |
| Y | N | Melanoma (HBOC) | | | | |
| Y | N | Pancreatic Cancer (HBOC / LYNCH) | | | | |
| Y | N | Other Cancers | | | | |
| Y | N | Have you or anyone in your family had genetic testing for a cancer syndrome? If YES, WHEN:_____ Results: _____ | | | | |

## Breast Cancer Risk Model Information:

Your current height (ft/in) _____
Your current weight (lbs) _____
Your menopausal status:
☐ Pre-menopausal
☐ Peri-menopausal
(time before menopause marked by irregular cycles)
Age of onset _____
Your age at time of first menstrual period _____
Your age at time of first live birth _____

Did you ever use Hormone Replacement Therapy? Yes ☐ No ☐
If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ Dont know
If yes, are you a: ☐ Current user: How many years ago did you start? _____
How many years do you intend to use? _____
☐ Past user: How many years ago did you stop using? _____
Have you ever had a breast bic ☐ Yes ☐ No
If yes, do you know your diagnosis? _____
Number of daughters _____
Number of sisters _____
Number of maternal aunts (mother's sisters) _____
Number of paternal aunts (father's side) _____

Patient's Signature:_____ Date:_____