CAPITAL WOMEN'S CARE
Working Together for Women's Health

Hereditary Cancer Questionnaire

Name: _____ Date of Birth: _____ Provider seeing today: _____

Instructions: please circle YES if you and/or any relatives have or have had the cancers listed below. Only consider first or second degree relatives (only first degree for pancreatic cancer).

Mother/Father/Sister/Brother/Your Children = First degree relatives
Uncle/Aunt/Grandparents/Nephew/Niece = Second degree relatives

CIRCLE YES OR NO			Specify Relative	Specify Cancer	Age at Diagnosis (Approximately)
NO	YES	Breast cancer in yourself			
NO	YES	Breast cancer diagnosed before the age of 50			
NO	YES	Three of more breast cancers ***on the same side of the family***			
NO	YES	Ashkenazi Jewish descent with at least one relative with breast cancer			
NO	YES	Ovarian Cancer			
NO	YES	Pancreatic Cancer in a ***first degree relative***			
NO	YES	Colon, rectal or uterine cancer diagnosed before the age of 50			
NO	YES	Three or more family members ***on the same side of the family*** with the following cancers: colon, rectal, uterine, ovarian, stomach, small intestine, kidney, or brain			

FOR OFFICE USE ONLY

- ☐ Patient is NOT appropriate for testing
- ☐ Patient is appropriate for testing
- ☐ Patient offered genetic testing: ACCEPTED or DECLINED

HCP Signature:_____ Date:_____