

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know.
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	<input type="checkbox"/> Y <input type="checkbox"/> N		
Colorectal or uterine cancer at 64 or younger	<input type="checkbox"/> Y <input type="checkbox"/> N		

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

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)	
Patient Signature _____	Date _____
Healthcare Provider Signature _____	Date _____
Office Use Only Patient offered hereditary cancer genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Accepted <input type="checkbox"/> Declined If yes, which test? <input type="checkbox"/> BRACAnalysis® with Myriad myRisk® <input type="checkbox"/> Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with Myriad myRisk® <input type="checkbox"/> COLARIS®PLUS with Myriad myRisk® <input type="checkbox"/> COLARIS AP®PLUS with Myriad myRisk® <input type="checkbox"/> Single Site Testing <input type="checkbox"/> Myriad myRisk® Update <input type="checkbox"/> Other: _____	
Follow-up appointment scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of next appointment: _____