Shoemaker OB GYN

Patient's name _____ D.O.B _____ **Date** _____

Risk assessment for Hereditary Cancers

(Please circle YES or NO. If yes, list relationship to relative and their age of diagnosis)

1st degree relatives: Mother, Father, Brother, Sister, or Children
2nd degree relatives: Aunts, Uncles, Grandparents, Grandchildren, Nieces, and Nephews
3rd degree relatives: Great-Grandparents, 1st cousins

Breast and Ovarian Cancer

Y/ N Have you, **OR** a relative(s) ever been diagnosed with breast cancer at age 45 or younger?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Have you, **OR** a relative(s) ever been diagnosed with ovarian cancer?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Has any male relative ever been diagnosed with breast cancer?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Have you, **OR** a relative(s) ever been diagnosed with multiple breast cancers?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Do you have 3 or more relatives from the same side of the family that have had breast cancer?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Are you of Ashkenazi Jewish ancestry?

Colon and Uterine Cancer

Y/N Have you, **OR** a relative ever been diagnosed with colon cancer before age 50?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Have you, **OR** a relative ever been diagnosed with endometrial (uterine) cancer before age 50?

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Y/N Have you, **OR** a relative ever been diagnosed with one of the following cancers? (specify cancer)

Ovarian, stomach (gastric), pancreas, ureter/renal pelvis, biliary tract, brain, & small bowel.

WHO? (Maternal/Paternal)_____ **AGE(S)**_____

Genetic Testing History

Y/N Have you **OR** any member of your family ever had genetic testing for a hereditary risk of cancer?

If yes, please explain_____

Candidate for genetic testing **Y/N** Patient offered genetic testing **Y/N** ___**accepted** ___**declined**

***MD Signature** _____ *Date*_____ ***Patient Signature**_____ *Date*_____