Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name		Date of Birth	Age
Gender (M/F)	Today's Date (MM/DD/YY)	Health Care Provider	

Please mark below if there is a personal or family history of any of the following cancers. If yes, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, cousins, great-grandparents, nieces, nephews, half-siblings, grandchildren.

CANCER	YOU	Age of Diagnosis	SIBLINGS/ CHILDREN	Age of Diagnosis	MOTHER'S SIDE	Age of Diagnosis	FATHER'S SIDE	Age of Diagnosis
For example: Colon/rectal cancer	***None***	***------***	***Brother***	***36 yrs***	***Aunt Cousin***	***44 yrs 58 yrs***	***Grandfather***	***65 yrs***
BREAST AND OVARIAN CANCER								
Breast Cancer *(Male or Female)*								
Ovarian Cancer *(Peritoneal/Fallopian tube)*								
Breast cancer in both breasts OR multiple primary breast cancers								
Male Breast Cancer								
Pancreatic cancer or aggressive prostate cancer* *(*Gleason Score≥7)*								
Are you of Ashkenazi Jewish descent? O YES O NO								
COLON AND ENDOMETRIAL CANCER								
Endometrial *(Uterine)* cancer								
Colon/rectal cancer								
Ovarian cancer *(Peritoneal/Fallopian tube)*								
Stomach (*Gastric*)/Small bowel cancer								
Kidney, urinary tract, biliary tract cancer								
Pancreatic cancer								
Brain cancer								
Sebaceous adenomas								
10 or more lifetime colon/rectal polyps *(specify #)*								
MELANOMA								
Melanoma								
Pancreatic cancer								

OTHER CANCER (*specify cancer type*) _____

Have your or anyone in your family had genetic testing for a hereditary cancer syndrome?
If Yes, Who? _____ What gene(s)? _____ What was the result? _____

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature	Date
Health Care Provider's Signature	Date

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Patient offered hereditary cancer genetic testing? O YES O NO O ACCEPTED O DECLINED

If Yes, which test? O BRAC*Analysis*® with Myriad myRisk® O Multisite 3 BRAC*Analysis* REFLEX to BRAC*Analysis* with Myriad myRisk

O COLARIS®PLUS with Myriad myRisk O COLARIS *AP*®PLUS with Myriad myRisk O Single Site Testing O Myriad myRisk Update

O Other: _____

Follow-up appointment scheduled: O YES O NO Date of Next Appointment: _____

Myriad Genetic Laboratories, Inc. • 320 Wakara Way, Salt Lake City, Utah 84108 • 800-469-7423 • www.MyriadPro.com

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