Risk Assessment for Hereditary Breast and Ovarian Cancer and Lynch Syndrome

Patient Name: _____ Date of Birth: _____

Physician: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to **YOU and/or YOUR FAMILY** (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt
First Cousins Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

	COLON & UTERINE CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y N	Uterine (endometrial) cáncer before 50			
Y N	Colorectal cáncer before 50			
Y N	Ovarian, stomach, kidney/urinary tract, brain or small bowel cancer			
Y N	Two or more of the above cancers			
	BREAST & OVARIAN CANCER	**SELF**	**FAMILY MEMBER**	**AGE AT DIAGNOSIS**
Y N	Breast cancer at age 50 or younger			
Y N	Ovarian cancer			
Y N	Two primary (unrelated) breast cancers in the same person			
Y N	Male breast cancer			
Y N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y N	Jewish ancestry with breast, ovarian, or pancreatic cancer			
Y N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY	__ Patient offered genetic testing:
__ Candidate for further risk assessment and/or genetic testing	__ Accepted
__ Information given to patient to review	__ Declined
	__Test not indicated
	Healthcare Professional's Signature Date