Hereditary Cancer Syndrome Risk Assessment

Patient Name: _____ Provider: _____

Date of Birth: _____ Date Completed: _____ Insurance: _____

This is a screening tool for the common features of inherited cancer syndromes. Your health care provider requests this information in order to provide you with the best care possible. Please complete as best you can, thank you!

- Please Circle (Y) for those that apply to **YOU** and/or **YOUR FAMILY** (on both your mother's and father's side).
- Each statement should be answered individually, so you may list the same cancer diagnosis more than once.
- You and the following family members should be considered:

Mother, Father, Brother, Sister, Children, Nieces/Nephews
Paternal and Maternal Grandmothers, Grandfathers, Great Grandparents, Aunts, Uncles, Cousins

Y	N	Have you or a family member ever been tested for hereditary risk of cancer (genetic testing for BRCA, Lynch Syndrome or any other syndromes)? If yes, please describe:

		BREAST AND OVARIAN CANCER	SELF SIBLING CHILD	Relative Maternal	Relative Paternal	AGE @ DIAGNOSIS	Deceased? Y or N
Y	N	Breast cancer diagnosed at **50 years of age or younger** in you or any family members?					
Y	N	**Ovarian cancer** diagnosed in you or ANY other family members at **ANY** age?					
Y	N	**Male breast cancer** diagnosed in any family members at **ANY** age?					
Y	N	**Pancreatic cancer** diagnosed in any family members at **ANY** age?					
Y	N	**Three or more** cancers diagnosed on the **same side** of your family: **breast**, **prostate**, melanoma, ovarian/fallopian tube/peritoneal?					
Y	N	**Jewish** Ancestry with breast, pancreatic or ovarian cancer diagnosed in you or any family members?					

		COLON AND UTERINE CANCER	SELF SIBLING CHILD	Relative Maternal	Relative Paternal	AGE @ DIAGNOSIS	Deceased? Y or N
Y	N	Endometrial (Uterine) cancer **before age 50** diagnosed in any family members? **(if Self <64)**					
Y	N	Colon/Rectal cancer **before age 50** diagnosed in any family members? **(if Self <64)**					
Y	N	**Three or more** cancers diagnosed on the **same side** of your family: **colon**, **uterine**, ovarian, stomach, small bowel, kidney/urinary tract, pancreatic, or brain?					
Y	N	10 or more **cumulative colon polyps (precancerous adenomas)** in you or a family member?					

X- Patient's Signature: _____ **Date:** _____

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Patient indicated for hereditary cancer genetic testing? ☐ **YES** ☐ **NO** ☐ **ACCEPTED** ☐ **DECLINED**

Reason _____

☐ Integrated BRAC*Analysis*® with Myriad myRisk™
☐ COLARIS®PLUS with Myriad myRisk™
☐ COLARIS AP®PLUS with Myriad myRisk™

Healthcare Provider's Signature: _____ **Date:** _____