

Hereditary Cancer Assessment Clinical History Questionnaire



Patient's Full Name: _____ Date of Birth: _____ Today's Date: _____

Family Tree

Mother: Alive at age _____ Deceased at age _____

Father: Alive at age _____ Deceased at age _____

Sisters: Total _____ Ages _____

Brothers: Total _____ Ages _____

Daughters: Total _____ Ages _____

Sons: Total _____ Ages _____

Cancer Location	Personal	Age at Diagnosis	Parents, Siblings & Children	Age at Diagnosis	Maternal Extended Family	Age at Diagnosis	Paternal Extended Family	Age at Diagnosis
<input checked="" type="checkbox"/> EXAMPLE: <i>Gastric Cancer</i>	<i>Me</i>	<i>39</i>					<i>Grandfather</i>	<i>81</i>
<input type="checkbox"/> Bladder								
<input type="checkbox"/> Breast								
For Personal History of Breast Cancer: <input type="checkbox"/> Bilateral <input type="checkbox"/> IDC (Invasive duct carcinoma) <input type="checkbox"/> ILC (Invasive lobular carcinoma) <input type="checkbox"/> DCIS (Ductal carcinoma in situ) <input type="checkbox"/> LCIS (Lobular carcinoma in situ) <input type="checkbox"/> Surgery is occurring within the month and genetic results will impact surgery. Surgery date (if known): _____								
<input type="checkbox"/> Colorectal								
For Personal History of Colon Cancer: <input type="checkbox"/> Right-sided (ascending) <input type="checkbox"/> Left-sided (descending) <input type="checkbox"/> Transverse <input type="checkbox"/> Rectal <input type="checkbox"/> Unknown								
<input type="checkbox"/> Gastric								
<input type="checkbox"/> Kidney (Renal)								
<input type="checkbox"/> Ovarian								
<input type="checkbox"/> Melanoma								
<input type="checkbox"/> Pancreatic								
<input type="checkbox"/> Prostate <small>indicate Gleason Score</small>								
<input type="checkbox"/> Testicular								
<input type="checkbox"/> Uterine (Endometrial)								
<input type="checkbox"/> Other Cancer _____								
<input type="checkbox"/> Colon Polyps <small>indicate how many</small>								
For Personal History of Colon Polyps: <input type="checkbox"/> Adenomatous polyps, how many: ____ <input type="checkbox"/> Other polyps, type: _____, how many: ____								
<input type="checkbox"/> I, or a member of my family, have had genetic testing for hereditary cancer. (Describe below and provide a copy of the results, if possible.)								