

Risk Assessment for Hereditary Breast and Ovarian Cancer and Lynch Syndrome

Patient Name: _____

Physician: _____

Date of Birth: _____

Today's Date: _____

This is a screening tool for Cancer that runs in Families. Please consider the following Family Members when completing the form:

1st Degree Relatives = Mother/Father/Sister/Brother/Children

2nd Degree Relatives = Aunt/Uncle/Grandparent/Niece/Nephew **3rd Degree Relatives** = Cousin/Great Grandparent

Have YOU or ANY OF YOUR RELATIVES been tested (BRCA/Colaris) for a Hereditary Cancer Syndrome? YES NO

Have YOU ever been Diagnosed with Cancer? What Site: Age:

COLON & UTERINE CANCER (Lynch Syndrome/Colaris)		SELF	Your Relationship to Family Member		Age at Diagnosis
YES	NO		Mother's Side	Father's Side	
Y	N				
Uterine (Endometrial) Cancer before Age 50					
Y	N				
Colon (Colorectal) Cancer before Age 50					
Y	N				
2 or more Relatives on Same Side of Family with any of the following cancers (circle): <i>Colon, Uterine/Endometrial, Ovarian, Stomach, Small Bowel, Brain, Kidney/Urinary Tract, Ureter, Renal Pelvis</i>					
Y	N				
Family member with know Lynch Syndrome Mutation					

BREAST & OVARIAN CANCER (HBOC/BRACAnalysis)		SELF	Your Relationship to Family Member		Age at Diagnosis
YES	NO		Mother's Side	Father's Side	
Y	N				
Breast Cancer at Age 45 or Younger (in Self, 1st or 2nd Degree Relative)					
Y	N				
Ovarian Cancer at Any Age (in Self, 1st or 2nd Degree Relative)					
Y	N				
2 Relatives on Same Side of Family with Breast Cancer - 1 of them under the Age of 50					
Y	N				
3 Relatives on Same Side of Family with Breast Cancer at Any Age					
Y	N				
Multiple Breast Cancers in the Same Person (in the same breast OR both breasts)					
Y	N				
Triple Negative Breast Cancer (ER, PR and Her2 Negative Receptor Status)					
Y	N				
Male Breast Cancer at Any Age					
Y	N				
Pancreatic Cancer with Breast OR Ovarian Cancer in the same person or on same side of the family					
Y	N				
Ashkenazi Jewish ancestry with Breast OR Ovarian Cancer in same person or on same side of family					
Y	N				
Family member with a known BRCA Mutation					

Is there any other Cancer in you or a Family Member not listed above? If yes, please provide Site, Relationship & Age:

Patient's Signature: _____

Date: _____

For Office Use Only:

- Based on Personal & Family History, testing is not indicated for the Patient at this time
- Genetic Testing Recommended for Patient: BRACAnalysis (HBOC) or Colaris (Lynch)
 - Patient Accepted Patient Declined

HCP Signature: _____