natera | Empower™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Is there cancer in your family? Learn if hereditary cancer testing is right for you. For more information text EMPOWER to 636363

Is there a history of any of the following in you or your family? **Please check all that apply.** (Relatives include your parents, brothers/sisters, children, uncles, aunts, grandparents, grandchildren, nieces, nephews, or half-siblings)

Pancreatic Cancer
- ☐ Pancreatic cancer (any age)

Ovarian Cancer
- ☐ Ovarian cancer (any age)

Uterine Cancer
- ☐ Uterine cancer under age 50

Breast Cancer
- ☐ At age 50 or younger
- ☐ 2 or more breast cancers in the same person (at any ages)
- ☐ Male breast cancer (any age)
- ☐ Personal history of breast cancer (any age)

If yes, was it:
☐ Triple Negative ☐ Metastatic

Colon/Rectal Cancer
- ☐ Personal history of colon/rectal cancer (any age)
- ☐ Relative with colon/rectal cancer under age 50
- ☐ 10 or more colon polyps: Number of polyps _____

Prostate Cancer
- ☐ Metastatic (stage 4 or advanced) prostate cancer
- ☐ Personal history of prostate cancer: Gleason Score _____

- ☐ **3 family members at any age with the following cancers on the same side of the family:** breast and/or prostate, uterine/endometrial and/or colorectal
- ☐ **Ashkenazi Jewish ancestry**
- ☐ **Unknown or limited family history (adopted or less than 2 female relatives living past age 45). Please Explain:** _____
- ☐ **Known hereditary cancer gene mutation in the family. Please list gene if known:** _____
- ☐ **Other cancers not listed above**

Checked any of the boxes? If yes, please fill out the next section. Hereditary cancer testing can help you understand if you or your relatives have an increased risk for developing cancer, and help guide your medical care.

Cancer site	Person (yourself or blood relative's relationship to you)	Approximate age at diagnosis	Side of the family		Relative deceased?
			Mother's	Father's	
Example: Breast Cancer	Aunt	42	☒	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Please check the box if any above relative is willing to be tested ☐

Breast cancer risk assessment tool. Your answers may determine if you are eligible for enhanced breast screening:

1. Height ____ ft ____ in 2. Weight _____ lbs
3. Have you had children? ☐ Yes ☐ No How old were you when you had your first child? _____
4. Approximate age at first menstrual period? _____
5. Have you gone through menopause? ☐ Yes ☐ No ☐ Ongoing If yes, at approximately what age? _____
6. Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No
7. Have you ever used hormone replacement therapy? ☐ Yes ☐ No ☐ Ongoing Start date: _____
   If yes, what type? ☐ Estrogen ☐ Estrogen+Progesterone ☐ I don't know End date: _____
8. Number of relatives: Sisters: _____ Daughters: _____ Maternal aunts: _____ Paternal aunts: _____ Maternal half-sisters: _____ Paternal half-sisters: _____
9. Have you ever had a breast biopsy? ☐ Yes ☐ No If yes, what was the result? ☐ Hyperplasia (no atypia) ☐ Atypical hyperplasia ☐ LCIS ☐ I don't know
10. Have you had your breast density assessed by mammogram? ☐ Yes ☐ No ☐ Unknown

If know, complete ONE of the following:
☐ **VAS percentage density** ____-____ % ☐ **Volpara volumetric density** ____-____%
☐ **BI-RADS ATLAS density:** ☐ Fatty ☐ Average ☐ Heterogeneously dense ☐ Extremely dense ☐ Unknown

Signatures

Patient Name	Patient Signature	Date
Provider Name	Provider Signature	Date

For Office Use Only

Patient offered hereditary cancer genetic testing (check all that apply)
☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**
Patient previously tested ☐ **Yes** ☐ **No**

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