RISK ASSESSMENT FOR HEREDITARY CANCER SYNDROMES G#: _____

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Provider seeing Today: _____

This is a screening tool for cancer that runs in families. Consider the following family members:

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 for a Hereditary Cancer Syndrome? ☐ **YES** ☐ **NO**

If yes, what test? _____ **What was the result?** _____

		COLON, UTERINE or OVARIAN CANCER (Lynch syndrome)	**SELF**	**WHICH FAMILY MEMBER(S)**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	**YOU** had/have colorectal or uterine cancer **BEFORE AGE 65**				
Y	N	1 first degree relative with colorectal or uterine cancer **BEFORE AGE 50**				
Y	N	2 colorectal or uterine cancers, **ONE BEFORE AGE 50**				
Y	N	3 or more Lynch syndrome cancers **AT ANY AGE** (including colorectal, uterine, ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis)				

		HEREDITARY BREAST & OVARIAN CANCER (HBOC syndrome)	**SELF**	**WHICH FAMILY MEMBER(S)**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	N	**YOU** had/have breast cancer **AT ANY AGE**				
Y	N	Ovarian cancer **AT ANY AGE**				
Y	N	Breast cancer **BEFORE AGE 50**				
Y	N	3 or more breast cancers **AT ANY AGE**				
Y	N	Ashkenazi Jewish ancestry and breast cancer **AT ANY AGE**				
Y	N	Pancreatic cancer **OR** male breast cancer **OR** Metastatic Prostate cancer **AT ANY AGE**				

Patient's signature: _____ Today's date: _____

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☐ Patient meets criteria for genetic testing: ☐ YES ☐ NO

☐ Patient **DECLINED** recommended genetic test: ☐ YES ☐ NO

If **DECLINED**, provide reason: _____

Patient signature if **declining** recommended testing: _____

Healthcare Provider Signature: _____