Cancer Risk Assessment

Name______________________________ Date of Birth________________ Date Completed____________

This form will let us know if you are a candidate for genetic cancer testing. Please fill out the top portion.

Include Parents, Siblings, Children, Aunts, Uncles, Grandparents, Nieces, and Nephews, write the relative's relationship to you and his/her age in the box.

Cancer	**Self, Siblings, Children**	**Mother or Relatives on Mother's Side**	**Father or Relatives on Father's Side**
Breast Cancer **before** age 50?			
Breast Cancer **after** age 50? (if 2 breast cancers, 1 must be before age 50, if 3 or more can be any age)			
Male Breast Cancer?			
Ovarian Cancer?			
Endometrial (Uterine) Cancer before age 50?			
3 or more Endometrial and/or Colon Cancers on the same side of the family at any age?			
Colon Cancer before age 50?			
Pancreatic Cancer?			
Are you of Ashkenazi Jewish ancestry?			

For Office Use Only

Provider Initials _______

Patient Was Offered Genetic Testing ____ / Accepted ____yes ____no /Reason_____________________

Age _____
Height_____
Weight_____
Ancestry__________
Ever had a bone marrow transplant?_____
Ever had a blood transfusion?_______ if yes, dates__________________________
Age of first period_____
Age of menopause(last period) _____
Age at first delivery_____

Ever used hormones after menopause? _________
How long on hormones?_____
Was it Estrogen, Progesterone or Combined?_________
Did you have dense breasts on a mammogram?________
Number of Daughters_____
Number of Sisters_____
Number of Maternal Aunts_____
Number of Paternal Aunts_____