Family history questionnaire

MyRisk™
Hereditary Cancer Test

Personal information

Patient name	Date of birth	Healthcare provider	Today's date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based on your personal and family history of cancer. The following blood relatives should be considered: **parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.** For cancer sites with a '1st-degree relative' notation, only parents, siblings, and children should be considered.

Do you have personal history of:	Yes (Y) / No (N)	Which cancer?	Age at diagnosis?
Breast, ovarian, colon, rectal or pancreatic cancer at any age	☐ Yes ☐ No		
Uterine cancer at 64 or younger	☐ Yes ☐ No		

Do you have family history of:	Yes (Y) / No (N)	Maternal (M) Paternal (P)	Which relative?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Yes ☐ No	☐ M ☐ P		
Two different breast cancers in one relative at any age	☐ Yes ☐ No	☐ M ☐ P		
Three breast cancers in relatives on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Ovarian cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Male breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Triple negative breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Yes ☐ No	☐ M ☐ P		
Pancreatic cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Metastatic or high-risk prostate cancer at any age (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Colon cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Uterine cancer at 49 or younger (1st-degree relative)	☐ Yes ☐ No	☐ M ☐ P		
Three colon and/or uterine cancers on the same side of the family at any age	☐ Yes ☐ No	☐ M ☐ P		
Do you have family history of other cancers?	List them here:			
Have you or anyone in your family had genetic testing for hereditary cancer?	Who?		What gene?	Result?

Cancer risk assessment review (to be completed after discussion with your healthcare provider)

Patient signature	Date
Healthcare provider signature	Date

Office use only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No / ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with MyRisk™ / ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with MyRisk™

☐ COLARIS® PLUS with MyRisk™ / ☐ COLARIS AP® PLUS with MyRisk™ / ☐ Single site testing / ☐ MyRisk™ Update Test

☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____