MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

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 'first-degree relative' notation, only parents, siblings, and children should be considered.

Do you have a personal history of **breast, ovarian, or pancreatic cancer** at any age?	○ Y ○ N
Do you have a personal history of **uterine or colorectal cancer** at age 64 or younger?	○ Y ○ N

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	○ Y ○ N		○ M ○ P	
Two different **breast cancers** in one relative at any age	○ Y ○ N		○ M ○ P	
Three **breast cancers** in relatives on the same side of the family at any age	○ Y ○ N		○ M ○ P	
Ovarian cancer at any age	○ Y ○ N		○ M ○ P	
Male breast cancer at any age	○ Y ○ N		○ M ○ P	
Ashkenazi Jewish ancestry with **breast cancer** at any age	○ Y ○ N		○ M ○ P	
Pancreatic cancer at any age (1st degree relative)	○ Y ○ N		○ M ○ P	
Metastatic prostate cancer at any age (1st- degree relative)	○ Y ○ N		○ M ○ P	
Colon or **uterine cancer** at 49 or younger (1st- degree relative)	○ Y ○ N		○ M ○ P	
3 or more breast or aggressive prostate cancers on the same side of the family at any age	○ Y ○ N		○ M ○ P	
3 or more colon or endometrial cancers on the same side of the family at any age	○ Y ○ N		○ M ○ P	
Do you have a family history of **other cancers**?	○ Y ○ N	**List them here:**		
Have you or anyone in your family had genetic testing for hereditary cancer?	○ Y ○ N	**Who?**	**What gene(s)?**	**What was the result?**

Medical History Questions

Height (ft. and in.)	Weight (lbs.)	Age at first menstrual period:

Are you: ○ Pre-menopausal ○ Peri-menopausal ○ Post-menopausal **Age at menopause:**_____

Have you ever had a live birth? ○ No ○ Yes **Your age at first child's birth:** _____

Have you ever used Hormone Replacement Therapy? ○ No ○ Yes

If Yes, treatment type? ○ Combined ○ Estrogen Only ○ Progesterone only

If Yes, are you a: ○ **Current user:** Started_____years ago, intended use for_____more years

○ **Past user:** Stopped_____years ago

Please indicate if you have had a breast biopsy showing one or more of the following results:

○ N/A (No biopsy or none of the listed results) ○ Hyperplasia ○ Atypical Hyperplasia

○ Lobular Carcinoma in Situ (LCIS) ○ Biopsy with unknown or pending results)

Information about your female relatives: Number of maternal aunts Number of paternal aunts

Number of daughters:_____ Number of sisters:_____ **(mother's sisters):**_____ **(father's sisters):** _____

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? ○ BRAC*Analysis*® with Myriad myRisk® ○ Multisite 3 BRAC*Analysis*® REFLEX to BRAC*Analysis*® with Myriad myRisk®

○ COLARIS®PLUS with Myriad myRisk® ○ COLARIS *AP*®PLUS with Myriad myRisk® ○ Single Site Testing ○ Myriad myRisk® Update Test

○ Other: _____

Follow-up appointment scheduled? ○ Yes ○ No Date ofnext appointment:_____

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