MYRIAD myRisk® Hereditary Cancer

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name	Date of Birth	Age

Gender (M/F)	Today's Date (MM/DD/YYYY)	Health Care Provider

Your Personal & Family History of Cancer is Important to Provide You With the Best Care Possible

Please mark "Yes" or "No" below if there is a **personal or family history** of any of the following cancers.
If yes, indicate family relationship and age at diagnosis in the appropriate column.

Include both sides of your family and list each member separately: Parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, and half-siblings.

Personal and Family History Have you or your family members been diagnosed with any of the following:		YOU	SIBLINGS / CHILDREN	MOTHER'S SIDE	FATHER'S SIDE
		Age	Family Member and Age	Family Member and Age	Family Member and Age
EXAMPLE: Breast cancer	☒ Y ○ N	Age 49	Sister 55, Daughter 33	Aunt #1 67 Aunt #2 45	Grandma 84
Breast cancer before age 50	○ Y ○ N				
2 or more separate **breast cancers** in one person, one at age 50 or younger	○ Y ○ N				
2 or more people in my family *(can include me)* with **breast cancer**, one at age 50 or younger	○ Y ○ N				
Ovarian (peritoneal/fallopian tube) cancer at any age	○ Y ○ N				
Triple Negative Breast cancer at age 60 or younger (ER-, PR-, HER2- Pathology)	○ Y ○ N				
3 or more of these cancers on same side of the family at any age: **pancreatic, breast**, or **aggressive prostate*** *Gleason Score ≥7	○ Y ○ N				
Male **breast cancer** at any age	○ Y ○ N				
Ashkenazi Jewish ancestry with **breast or pancreatic cancer** at any age	○ Y ○ N				
Pancreatic cancer or aggressive prostate cancer and one relative with **breast cancer at age 50 or younger**	○ Y ○ N				
20 or more **colon/rectal polyps** found in 1 person throughout their lifetime. Specify number_____	○ Y ○ N				
Colon/rectal or **endometrial (uterine) cancer** before age 50	○ Y ○ N				
Personal history of **endometrial (uterine) cancer** at any age†	○ Y ○ N				
TWO individuals in my family (can include me): at least 1 with **colon/rectal *or* endometrial (uterine) cancer** at any age AND ALSO 1 diagnosed before age 50 with a Lynch-associated‡ cancer	○ Y ○ N				
THREE OR MORE individuals in my family (can include me) with a **Lynch-associated* cancer** at any age, with at least 1 being a **colon/rectal** or **endometrial (uterine) cancer**	○ Y ○ N				

† **PREMM$_{(1,2,6)}$ Score ≥ 5%**
‡ **Lynch-associated cancers include: colon, endometrial(uterine), stomach, ovarian, pancreatic, brain, small bowel, kidney, urinary tract, biliary tract, sebaceous (skin gland).**

Have your or anyone in your family had genetic testing for a **hereditary cancer syndrome**?	○ Y ○ N	If Yes, Who? _____ What gene(s)? _____ What was the result? _____

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

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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

○ Other: _____

Follow-up appointment scheduled: ○ YES ○ NO Date of Next Appointment: _____

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