ASHMED VÁZQUEZ MD, PC
OBSTETRICS AND GYNECOLOGY

FAMILY HISTORY QUESTIONAIRE FOR COMMON HEREDITARY CANCER SYNDROMES

Patient Name ________________________________ DOB________________ Date____________

Please circle **Yes** to those that apply to **You and/or Your Family** (on both your mother's or father's side). You may list the same cancer diagnosis more than once as you answer this questions.

Yes No	**BREAST AND OVARIAN CANCER**	**YOU or FAMILY MEMBER?** **Specify Family Member or Self**	**Age at Diagnosis**
Yes No	Breast cancer before age 50		
Yes No	Ovarian cancer		
Yes No	Breast cancer in both breasts or multiple primary breast cancer		
Yes No	Both breast and ovarian cancer (in an individual or a family)		
Yes No	Male breast cancer		
Yes No	2 or more breast or ovarian cancers (in an individual or a family)		
Yes No	Ashkenazi Jewish ancestry & personal or family history of breast or ovarian cancer		

Yes No	**COLON AND UTERINE CANCER**	**YOU or FAMILY MEMBER?** **Specify Family Member or Self**	**Age at Diagnosis**
Yes No	Uterine cancer before age 50		
Yes No	Colorectal cancer before age 50		
Yes No	Both uterine and colorectal cancer (in an individual or family)		
Yes No	2 or more uterine or colorectal cancers (in an individual or a family)		
Yes No	Uterine and/or colorectal cancer AND ovarian, stomach, kidney/urinary tract, brain OR small bowel cancer (in an individual or family)		
Yes No	10 or more colon polyps found in a lifetime		

___ Candidate for further risk assessment and/or genetic testing
___ Information given to patient to review
___ Follow up appointment scheduled Date_________

___Patient offered genetic testing
___ Accepted ___ Declined

Patient's Signature ____ Date _______________

Physician's Signature____ Date _______________