INVITAE

Cancer family history questionnaire

Patient name	Patient DOB (MM/DD/YYYY)	Age	Gender

Healthcare provider	Today's date (MM/DD/YYYY)

PERSONAL AND FAMILY HISTORY OF CANCER

Please include: yourself, parents, siblings, children, grandparents, grandchildren, aunts, uncles, nephews, nieces, half siblings, first cousins, great grandparents, and great grandchildren. Please be as thorough and accurate as possible.

☐ Adopted/unknown family history

	CANCER	YOU Age of diagnosis	PARENTS/SIBLINGS/ CHILDREN	Age of diagnosis	RELATIVES ON YOUR MOTHER'S SIDE	Age of diagnosis	RELATIVES ON YOUR FATHER'S SIDE	Age of diagnosis
☐ Y ☐ N	EXAMPLE: Breast Cancer	44	—	—	Grandmother Aunt	47 51	Cousin	54
☐ Y ☐ N	BREAST CANCER							
☐ Y ☐ N	OVARIAN CANCER (Peritoneal/fallopian tube)							
☐ Y ☐ N	UTERINE/ENDOMETRIAL CANCER							
☐ Y ☐ N	PROSTATE CANCER							
☐ Y ☐ N	COLON/RECTAL CANCER							
☐ Y ☐ N	PANCREATIC CANCER							
☐ Y ☐ N	OTHER CANCER(S) (Specify cancer type)							
☐ Y ☐ N	Are you of Ashkenazi Jewish descent? *(Jewish with ancestors from Central or Eastern Europe)*							
☐ Y ☐ N	Have you or anyone in your family had genetic testing for a hereditary cancer syndrome? *(Please describe and include a copy of result if possible)*							

HEREDITARY CANCER FEATURES

Please complete this section with your healthcare provider

YOUR PERSONAL HISTORY

HEREDITARY BREAST CANCER SYNDROMES*

- ☐ Breast cancer diagnosed at or before age 50
- ☐ Two primary occurrences of breast cancer
- ☐ Male breast cancer
- ☐ Triple negative breast cancer diagnosed at or before age 60
- ☐ Ovarian cancer
- ☐ Pancreatic cancer
- ☐ Metastatic or intraductal/cribriform prostate cancer
- ☐ Ashkenazi Jewish ancestry, regardless of personal history of cancer

HEREDITARY COLON CANCER SYNDROMES

- ☐ Colorectal cancer before age 50
- ☐ Endometrial/uterine cancer before age 50
- ☐ Tumor with mismatch repair (MMR) deficiency†
- ☐ Two or more Lynch syndrome cancers‡
- ☐ One Lynch syndrome cancer and one or more relatives with a Lynch syndrome cancer

YOUR FAMILY HISTORY

HEREDITARY BREAST CANCER SYNDROMES

- ☐ Relative with breast cancer at or before age 50
- ☐ Male relative with breast cancer
- ☐ Relative with ovarian cancer
- ☐ Relative with pancreatic cancer
- ☐ Relative with metastatic or intraductal/cribriform prostate cancer
- ☐ Three or more relatives with breast and/or prostate cancer
- ☐ A previously identified pathogenic variant ("mutation") in the family
- ☐ Ashkenazi Jewish ancestry, regardless of family history of cancer

HEREDITARY COLON CANCER SYNDROMES

- ☐ At least one first-degree relative with colon or endometrial cancer before age 50
- ☐ At least one first-degree relative with more than one Lynch syndrome cancer
- ☐ Two or more relatives with a Lynch syndrome cancer,‡ at least one before age 50
- ☐ Three or more relatives with a Lynch syndrome cancer
- ☐ A previously identified pathogenic variant ("mutation") in the family

* Including: Breast (female and male), ovarian, pancreatic, prostate cancer

† Via PCR, NGS, or IHC. Screening for MMR deficiency is recommended for all colorectal and endometrial cancer tumors and should be considered for other Lynch syndrome cancers.

‡ Including: Colon, endometrial/uterine, gastric/stomach, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, and brain cancer, as well as sebaceous adenomas

CANCER RISK ASSESSMENT REVIEW

To be completed after discussion with healthcare provider

If any of the boxes above are checked, this history has features that may indicate a hereditary cancer syndrome and warrants consideration of genetic testing.

Patient's signature	Date (MM/DD/YYYY)

Healthcare provider's signature	Date (MM/DD/YYYY)

For office use only:

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO | ☐ ACCEPTED ☐ DECLINED

Follow-up appointment scheduled: ☐ YES ☐ NO | Date of next appointment _____

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