# Cancer Family History Questionnaire

NCBC
National Consortium of Breast Centers, Inc.

Do **YOU** have a **Personal History** of any of the following?

| Updated 7/31/2023 | Yes or No | Age at Diagnosis |
|---|---|---|
| Breast Cancer diagnosed at age 50 or younger? | ____ Yes ____ No | |
| Triple Negative Breast Cancer at any age? | ____ Yes ____ No | |
| Bilateral (two breast cancers) at any age? | ____ Yes ____ No | |
| Metastatic (stage 4) Breast Cancer? | ____ Yes ____ No | |
| Male Breast Cancer? | ____ Yes ____ No | |
| Ovarian Cancer? | ____ Yes ____ No | |
| Pancreatic Cancer? | ____ Yes ____ No | |
| Are you of Ashkenazi Jewish ancestry and have breast cancer? | ____ Yes ____ No | |
| Colon/Colorectal Cancer at any age? | ____ Yes ____ No | |
| Endometrial Cancer at age 64 or younger? | ____ Yes ____ No | |
| 20 or more colon polyps in your lifetime? | ____ Yes ____ No | |

Do you have a **Family History** of any of the following?
(*The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles,*

Have **YOU** been tested for **hereditary risk of cancer**? Yes _____ No_____
(Genetic Testing/ e.g. BRCA or Lynch Syndrome) If so, when:_____ Result:_____

*nieces, nephews, on both sides of the family*)

| | Yes or No | Which Relative? | Maternal (Mother) or Paternal (Father) | Age at Diagnosis? |
|---|---|---|---|---|
| Breast cancer age 49 or younger | ___ Yes ___No | | ____M ____P | |
| 2 Breast Cancers in **one** relative at any age | ___ Yes ___No | | ____M ____P | |
| 3 breast cancers in relatives on the same side of family | ___ Yes ___No | | ____M ____P | |
| Ovarian cancer at any age | ___ Yes ___No | | ____M ____P | |
| Pancreatic cancer at any age in parents, children, siblings | ___ Yes ___No | | ____M ____P | |
| Male Breast cancer at any age | ___ Yes ___No | | ____M ____P | |
| Colon or endometrial cancer at age 49 or younger in parents, children or siblings | ___ Yes ___No | | ____M ____P | |
| Ashkenazi Jewish with breast cancer any age | ___ Yes ___No | | ____M ____P | |
| 3 relatives on the same side with Colon, Endometrial or other Lynch cancer**? | ___ Yes ___No | | ____M ____P | |

** *Lynch cancers: Colon, Endometrial, Stomach, Ovarian, Pancreatic, Small Bowel, Renal Pelvis, Brain, Sebaceous Carcinoma*

To the best of my knowledge, I have provided the most accurate answers to the above questions.
**Patient's signature**:_____
Date:_____

FOR OFFICE USE ONLY:
Did patient meet criteria for Genetic Education? ☐ YES ☐ NO ☐ MORE INFORMATION NEEDED

If YES, Patient: ☐ ACCEPTED Video ☐ DECLINED Video: Reason_____

If ACCEPTED, Patient: ☐ SUBMITTED MyRisk ☐ DECLINED Testing: Reason_____

**I _____ACCEPT or _____DECLINE genetic testing.**

**Patient's signature**:_____ Date:_____

**Witnessed by**:_____

**Witnessed by**:_____