CIRCULOGENE

Hereditary Cancer Questionnaire - Preventive Care

(to be completed by patients)

Patient Name:_____

Date of Birth:_____

Today's Date:_____

Instructions: This is a screening tool to help your doctor learn about your family history of cancer, so that they can talk to you about genetic testing, if you may benefit from it. Your doctor will review this form to look for patterns of hereditary cancer such as similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancers in the same person.

DOES CANCER RUN IN YOUR FAMILY? CHECK THOSE THAT APPLY.

Please do the best you can to fill out your family history of cancer below. Your doctor will need to know who had cancer, how old they were when they were diagnosed, and the type of cancer. Include only family members related to you by blood, such as your parents, grandparents, children, brothers, sisters, aunts, uncles, and cousins. If you share only one parent with a brother or sister, please make a note, so that your doctor knows.

	TYPE OF CANCER	YOURSELF/ PARENTS/ BROTHERS/ SISTERS/CHILDREN	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (MOTHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (FATHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)
☒	EXAMPLE: Colorectal Cancer	Me	42	Aunt Uncle		Aunt Uncle	46 58
☐	BREAST CANCER (in women or men)						
☐	OVARIAN CANCER (peritoneal/ Fallopian tube)						
☐	PROSTATE CANCER						
☐	PANCREATIC CANCER						
☐	UTERINE (Endometrial Cancer)						
☐	COLORECTAL CANCER						
☐	OTHER CANCER Type: _____						
☐	MORE THAN 10 COLORECTAL POLYPS						

☐ My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)

☐ I, or someone in my family, have had genetic testing for a hereditary cancer syndrome.
(Please describe and provide a copy of test result if possible)

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