

Risk Assessment for Hereditary Cancer Syndromes

Patient Name: _____ Physician: _____

Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

*Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins
Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather*

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary cancer syndromes. Share this information with your healthcare professional to help determine your hereditary cancer risk.

BREAST AND OVARIAN CANCER		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Breast cancer before age 50		
Y	N	Ovarian cancer		
Y	N	Two primary (unrelated) breast cancers in the same person or on the same side of the family		
Y	N	Male breast cancer		
Y	N	Triple negative breast cancer* (ER-, PR-, HER2-pathology)		
Y	N	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family		
Y	N	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family		
COLON AND UTERINE CANCER		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Uterine (endometrial) cancer before age 50		
Y	N	Colorectal cancer before age 50		
Y	N	Two or more Lynch syndrome cancers* in the same person or on the same side of the family		
(*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)				
POLYPOSIS SYNDROMES		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	10 or more cumulative (lifetime) colorectal adenomas (colon polyps)		
MELANOMA		SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y	N	Two or more melanomas in an individual or family		
Y	N	Melanoma and pancreatic cancer in an individual or family		
Y	N	Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:		

Patient's Signature

Date

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Candidate for further risk assessment and/or genetic testing:
 HBOC Lynch Polyposis Melanoma

Patient offered genetic testing: Accepted Declined

Information given to patient to review

Follow-up appointment scheduled

Date: _____

Healthcare Professional's Signature

Date

*For a better understanding of triple negative breast cancer, please ask your healthcare provider.

Assessment criteria based on medical society guidelines. For these individuals society guidelines go to www.myriadtests.com/patient_guidelines

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