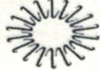

Rhode Island Hospital
A Lifespan Partner

The Comprehensive Cancer Center

FAMILY HISTORY QUESTIONNAIRE FOR COMMON HEREDITARY CANCER SYNDROMES

Patient name: ______________________________ Date of birth: ____________ MRN: ______________

Date completed: ______________ What is your family's ethnic background? ____________________

Are you of Eastern European Jewish decent? ____ Yes ____ No Your physician is: ____________________

Have you or your family members ever had genetic testing for a hereditary cancer? ____ Yes ____ No

Please record a personal or family history of any of the following cancers. If yes, then indicate the family relationship and the age their cancer was identified in the appropriate column.

Cancer Type	YOURSELF (Patient)	Age at diagnosis	SIBLINGS / CHILDREN	Age at diagnosis	MOTHER'S SIDE (Your grandparents, aunts, uncles and cousins)	Age at diagnosis	FATHER'S SIDE (Your grandparents, aunts, uncles and cousins)	Age at diagnosis
For example: Breast cancer	none	____	Sister	42	Grandmother Aunt	60 54	none	____
Breast cancer								
Breast cancer in both breasts or Multiple breast cancers (2 or more times)								
Male breast cancer								
Ovarian cancer								
Melanoma								
Colorectal cancer								
Small bowel or other Intestinal cancer								
10 or more polyps								
Pancreatic cancer								
Prostate cancer								
Brain cancer								
Kidney or Urinary Tract cancer								
Thyroid cancer								
Other cancers								