

# **CENTRAL JERSEY ONCOLOGY CENTER**

## **FAMILY HISTORY QUESTIONNAIRE COMMON HEREDITARY CANCER SYNDROMES**

PATIENT NAME:	CJOC PHYSICIAN:
DATE OF BIRTH:	TODAY'S DATE:

Please place a check mark in the boxes below for yourself and family members who have had cancer as indicated. Consider parents, children, brothers, sisters, grandparents, aunts, uncles, and cousins.

### **YOU**

DIAGNOSIS	NO	YES	AGE OF DIAGNOSIS	MOTHER'S SIDE	Y*	N	FATHER'S SIDE	Y*	N
Breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Two or more breast cancers (bilateral or contralateral)?	<input type="checkbox"/>	<input type="checkbox"/>							
Ovarian cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Male breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Colon cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Two or more colon cancers in one individual?	<input type="checkbox"/>	<input type="checkbox"/>							
Uterine (endometrial) cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
10 or more colon polyps found in 1 or more exams?	<input type="checkbox"/>	<input type="checkbox"/>							
Melanoma?	<input type="checkbox"/>	<input type="checkbox"/>							
Pancreatic cancer?	<input type="checkbox"/>	<input type="checkbox"/>							
Other cancers: stomach, kidney/urinary tract, brain, small bowel, thyroid?	<input type="checkbox"/>	<input type="checkbox"/>							

Are you of Ashkenazi Jewish descent? (please circle) YES / NO

List any other cancers in you or your family: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*\*List all relatives (relation, not name) diagnosed with the above cancers, along with the age of diagnosis:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you checked yes in one or more boxes on this form, ask your doctor to assess your cancer history. If your history indicates that you may have an inherited risk of cancer, there is a blood test that can help determine if you are at risk for hereditary cancer.