

# **CENTRAL JERSEY ONCOLOGY CENTER**

## **FAMILY HISTORY QUESTIONNAIRE FOR 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?									
Two or more breast cancers (bilateral or contralateral)?									
Ovarian cancer?									
Male breast cancer?									
Colon cancer?									
Two or more colon cancers in one individual?									
Uterine (endometrial) cancer?									
10 or more colon polyps found in 1 or more exams?									
Melanoma?									
Pancreatic cancer?									
Other cancers: stomach, kidney/urinary tract, brain, small bowel, thyroid?									

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.