



Patient Name:	Physician:
Date of Birth:	Date Completed:
Are you of Ashkenazi Jewish descent? YES / NO (circle one)	

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.

Have you or any family members ever been diagnosed with:	You			Family Members			
	No	Yes	Age of diagnosis	No	Yes**	Mother's side (✓)	Father's side (✓)
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 one or more exams?							
Melanoma?							
Pancreatic cancer?							
Other cancers: stomach, kidney/urinary tract, brain, small bowel, thyroid							

List any other cancers in you or your family: _____

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

If you checked yes in one or more boxes on the Family History Questionnaire 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.

Please talk to your doctor about reducing your risk and possibly preventing cancer.