Loudoun Community Midwives

CANCER FAMILY HISTORY QUESTIONNAIRE

Patient Name:_____ Provider (today's visit):_____
Date of Birth:_____ Date:_____
Have you completed this questionnaire in the last 12 months? Yes/No

Aunts/Uncles, Grandparents, Nieces/Nephew, Grandchildren, 1st cousin and Great-grandparents
If your history exactly matches these questions check Y
If you are unsure of the exact age of diagnosis please indicate whether the diagnosis was above or below the age of 50 by writing 45 for below 50 diagnoses and 55 for above 50 diagnoses.

Cancer Family History	Check Y or N	Please list yourSELF or your FAMILY MEMBER listed above with CANCER			Age of Diagnosis
		SELF	MOTHER'S SIDE	FATHER'S SIDE	
Colon Cancer diagnosed before age 50	Y ☐ N ☐				
Endometrial/Uterine Cancer diagnosed before age 50 (Including yourself if diagnosed at any age)	Y ☐ N ☐				
Three or more of the following cancers on the same side the family at any age (including yourself): Colon, Endometrial, Ovarian, Gastric/Stomach, Pancreatic, Brain, Small Bowel, Renal/Pelvic, Biliary Tract, Sebaceous Adenomas	Y ☐ N ☐				
Breast Cancer diagnosed at age 50 or less (Including yourself if Triple Negative Breast Cancer diagnosed ≤ 60)	Y ☐ N ☐				
Ovarian Cancer at any age	Y ☐ N ☐				
One relative with breast cancer (could include yourself) diagnosed at age ≤ 50 and another relative with pancreatic or prostate at any age	Y ☐ N ☐				
Three or more of the following cancers on the same side of the family regardless of age (could include yourself): Breast, Ovarian, Pancreatic and/or Prostate	Y ☐ N ☐				
Male breast cancer diagnosed at any age	Y ☐ N ☐				
Ashkenazi Jewish ancestry with one breast, ovarian or pancreatic cancer in the family (could include yourself)	Y ☐ N ☐				
Have you ever been tested for BRCA or Lynch Syndrome before?	☐ Y ☐ N				

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☐ Patient is NOT appropriate for testing
☐ Patient is appropriate for testing
Patient offered genetic testing: ☐ Accepted OR ☐ Declined
HCP Signature: _____