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OB/GYN

Cancer Family History Questionnaire

TMC
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Name _____ Date of Birth _____

Please mark below if there is a personal or family history of any of the following cancers.
Please indicate which family member is affected & the age at diagnosis in the appropriate column.

	You	Age at Diagnosis	Siblings/ Children	Age at Diagnosis	Mother's Side	Age at Diagnosis	Father's Side	Age at Diagnosis
Example: Colorectal Cancer	None		Brother	36yrs	Aunt Cousin	44yrs 58yrs	Grand-father	65yrs
Breast Cancer								
Male Breast Cancer								
Multiple Breast Cancers in 1 person								
Breast Cancer in Both Breasts								
Ovarian or Fallopian Tube Cancer								
Pancreatic Cancer								
Uterine/ Endometrial Cancer								
Colorectal Cancer								
Stomach Cancer								
Kidney/Bladder Cancer								
Brain Cancer								
Small Bowel Cancer								
Melanoma								
Prostate Cancer								
Other _____								
Other _____								
Other _____								

Are you of Ashkenazi Jewish descent? ☐ Yes ☐ No

Patient Signature _____ Date _____