SUGAR LAND OB/GYN

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FAMILY HISTORY QUESTIONNAIRE

PATIENT INFORMATION				
FULL NAME (FIRST + LAST)		DATE OF BIRTH	AGE	MOTHER'S AGE
HEIGHT	WEIGHT	AGE OF FIRST PERIOD	YOUR AGE OF FIRST CHILD DELIVERED (IF APPLICABLE)	
ARE YOU MENOPAUSAL? ☐ YES ☐ NO	HAVE YOU EVER USED HORMONAL REPLACEMENT THERAPY? ☐ YES ☐ NO		IF YES, FOR HOW LONG?	ARE OF YOU JEWISH DECENT? ☐ YES ☐ NO

Please mark below if there is a personal or family history of any of the following cancers. Please indicate family relationship and age at time of diagnosis in the appropriate column. For degrees of connection please use the following definition:

1- Mother/Father/Sister/Brother/Children | 2 – Aunt/Uncle/Grandparent/Niece/Nephew | 3 – Cousin/ Great Grandparent/Great Aunt/Uncle

COLON AND UTERINE CANCER (COLARIS)			SELF	FAMILY MEMBER SIDE		AGE AT DIAGNOSIS
				MOTHER'S	FATHER'S	
Y	N	Have You had Uterine (endometrial) cancer at any age?				
Y	N	Uterine (endometrial) cancer before age 50? 1st or 2nd degree family members.				
Y	N	Colorectal cancer before age 50 (in self, 1st, or 2nd degree family members)				
Y	N	Two or more of the following cancers on the same side of the family: ☐ Colon ☐ Uterine ☐ Stomach ☐ Small Bowel ☐ Brain ☐ Kidney/Urinary Track ☐ Ureter ☐ Renal Pelvis				
Y	N	A family member with a known Lynch Syndrome mutation.				
BREAST AND OVARIAN CANCER (BRAC ANALYSIS)			**SELF**	**FAMILY MEMBER SIDE**		**AGE AT DIAGNOSIS**
				MOTHER'S	**FATHER'S**	
Y	N	Breast cancer under the age of 50 (in self, 1st, or 2nd degree family members)				
Y	N	Ovarian cancer at any age (in self, 1st, or 2nd degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer; one under the age of 50				
Y	N	Three relatives on the same side of the family with Breast, Ovarian, Pancreatic, and/or Prostate (Gleason score>6) cancer at any age.				
Y	N	Triple negative breast cancer under the age of 60 (receptor status negative for ER, PR, and HER2)				
Y	N	Male breast cancer at any age				
Y	N	Breast of Pancreatic cancer at any age of Ashkenazi Jewish Heritage				
Y	N	A family member with a known BRCA mutation				
Y	N	A family member with a known Hereditary Cancer mutation				

Are there any other cancers in you or your family members not listed above? If yes, please provide the family member's relationship to you, the site of their cancer and the age when they were diagnosed.

_____

PATIENT'S SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY:	GENETIC TESTING? ☐ Yes ☐ No	PATIENT DECLINED SIGNATURE:	FOLLOW UP DATE:
	PATIENT OFFERED TESTING? ☐ Accepted ☐ Declined		