South Shore
OBSTETRICS & GYNECOLOGY
Women's Health Care

ID #_____

Name	Date of Birth	Date

Family History (blood relative) ☐ NA, I am adopted and do not know my family history.

	Have you had?	Has blood relative had?	
If yes, circle below:	**Self**	**Mother side (specify)**	**Father side (specify)**
Arthritis			
Asthma			
Birth defects			
Blood disorder			
Cervical cancer			
Breast cancer	If you or your family has a history of: **Breast, Colon, and/or Ovarian, Uterine** cancer please complete the back side of this page.		
Colon cancer			
Ovarian Cancer			
Uterine Cancer			
Chickenpox			
Depression			
Diabetes			
Emphysema			
Endometriosis			
Goiter			
Gout			
Hay fever/allergies			
Heart disease (specify)			
Hepatitis (specify type)			
High Blood Pressure			
Kidney Disease (specify)			
Osteoporosis			
Stroke			
Thyroid disease			
Tuberculosis			
Twins or triplets			
Other			
Other			

Comments:

This page is to be filled out ONLY if you or your family has a history of: Colon, Uterine, Breast, and/or Ovarian cancer

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. If you circle Y (yes) to any statement below, you may be appropriate for hereditary cancer testing. When you circle Y, please provide the age of diagnosis and relationship of family member with cancer.

Mother/Father/Sister/Brother/Children = **1st Degree Relatives**
Aunt/Uncle/Grandparent/Niece/Nephew = **2nd Degree Relatives**
Cousin/Great Grandparent = **3rd Degree Relatives**

Have you or any of your relatives been tested for a hereditary cancer syndrome in the past? **YES NO**

		COLON AND UTERINE CANCER	**SELF**	**FAMILY MEMBER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	**N**	Uterine (endometrial) cancer before age 50				
Y	**N**	Colorectal cancer before age 50				
Y	**N**	Two or more of the following cancers on the same side of the family: ovarian, stomach, small bowel, brain, kidney/urinary tract, ureter or renal pelvis				
Y	**N**	A family member with a known Lynch Syndrome mutation				
		BREAST AND OVARIAN CANCER	**SELF**	**FAMILY MEMBER**		**AGE AT DIAGNOSIS**
				MOTHER'S SIDE	**FATHER'S SIDE**	
Y	**N**	Breast cancer at age 45 or younger (in self, first or second degree family members)				
Y	**N**	Ovarian cancer at any age (in self, first or second degree family members)				
Y	**N**	Two relatives on the same side of the family with breast cancer—with one under the age of 50				
Y	**N**	Three relatives on the same side of the family with breast cancer at any age				
Y	**N**	Triple negative breast cancer under the age of 60 (ER, PR and HER2 negative receptor status)				
Y	**N**	Male breast cancer at any age				
Y	**N**	Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family				
Y	**N**	Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family				
Y	**N**	A family member with a known BRCA mutation				

Is there any other cancer in you or your family members not listed above? I yes, provide site, relationship to you, and age of diagnosis:

Patient's Signature	**Date**

FOR OFFICE USE ONLY

- ☐ Patient is appropriate for further risk assessment and/or genetic testing
- ☐ Information given to patient to review
- ☐ Follow-up appointment scheduled on _____ (date)
- ☐ Patient offered genetic testing: Accepted OR Declined **Staff Signature:**_____