

Your Cancer Family History

Is there cancer in your family? Your family history affects your risk for cancer.

YOUR NAME	DATE OF BIRTH
HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? <input type="checkbox"/> Yes <input type="checkbox"/> No	TODAY'S DATE
TYPE OF CANCER	AGE DIAGNOSED

Do any of these statements apply to you?

<p>I am adopted with no family history.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>I have a personal or family history of Triple Negative Breast Cancer.</p> <p><input type="checkbox"/> Yes Who? _____ <input type="checkbox"/> No / Don't know</p>	<p>I have at least one grandparent of Ashkenazi Jewish descent.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No / Don't know</p>
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Please provide information below only for family members diagnosed with cancer.

Your children

Cancer?
 Yes (describe below)
 No / no children
 Don't know

FIRST NAME	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Your grandchildren

Cancer?
 Yes (describe below)
 No / no grandchildren
 Don't know

FIRST NAME	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Your brothers and sisters

Cancer?
 Yes (describe below)
 No / no siblings
 Don't know

FIRST NAME	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Your nieces and nephews

Cancer?
 Yes (describe below)
 No / no nieces or nephews
 Don't know

FIRST NAME	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Your biological mother

Cancer?
 Yes (describe below)
 No
 Don't know

FIRST NAME	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Your biological father

Cancer?
 Yes (describe below)
 No
 Don't know

FIRST NAME	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Her brothers and sisters
your aunts and uncles

Cancer?
 Yes (describe below)
 No / no siblings
 Don't know

FIRST NAME	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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His brothers and sisters
your aunts and uncles

Cancer?
 Yes (describe below)
 No / no siblings
 Don't know

FIRST NAME	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Her mother
your maternal grandmother

Cancer?
 Yes (describe below)
 No
 Don't know

FIRST NAME	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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His mother
your paternal grandmother

Cancer?
 Yes (describe below)
 No
 Don't know

FIRST NAME	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Her father
your maternal grandfather

Cancer?
 Yes (describe below)
 No
 Don't know

FIRST NAME	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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His father
your paternal grandfather

Cancer?
 Yes (describe below)
 No
 Don't know

FIRST NAME	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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Her other relatives
your first cousins, great aunts and uncles, great grandparents

Cancer?
 Yes (describe below)
 No
 Don't know

RELATIONSHIP	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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His other relatives
your first cousins, great aunts and uncles, great grandparents

Cancer?
 Yes (describe below)
 No
 Don't know

RELATIONSHIP	SEX	TYPE OF CANCER	AGE DIAGNOSED	AVAILABLE FOR TESTING?*
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*If your relative was diagnosed with cancer but is not available for testing please indicate the reason why (deceased, estranged, personal reasons, etc.). This information is required by some health plans to determine your eligibility for coverage.

<p>FOR OFFICE USE ONLY</p> <p>Does cancer family history meet any of these criteria?</p> <p><input type="checkbox"/> No relevant history</p>	<p><input type="checkbox"/> 1 person (patient or close relative) with cancer <input type="checkbox"/> 2 people on the same side of the family with cancer <input type="checkbox"/> 3 people on the same side of the family with cancer <input type="checkbox"/> No or limited family history. (Adoptees may need special consideration.)</p>	<p>Does patient meet screening criteria on reverse?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><input type="checkbox"/> Patient accepted testing Date drawn: <input type="checkbox"/> Patient declined testing</p>
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CLOSE RELATIVES