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PrimBio

Hereditary Cancer History Form

Name:_______________________________ Date of Birth:_________________________ Date Completed:______________________

Race:_______________________________ Gender: M or F Phone:_______________ Email:_______________________________

Have you ever taken a genetic test for hereditary colorectal cancer and/or breast cancer? (Check "**YES**" or "**NO**")

- ❑ **YES**
  - When?_____________________
  - Results of the test were?
    - ❑ Negative
    - ❑ Positive, which gene(s)?______________________________
- ❑ **NO**
  - Please complete the table below

Hereditary Colorectal Cancer Questionnaire

When completing this table, please provide information pertaining to either you and/or a family member.
Family members consist of:* ***parents, siblings, children, grandparents, aunts, uncles, nieces, nephews,* *and/or* ***cousins***

Family history of a known Lynch syndrome mutation (MLH1, MSH2, MSH6, PMS2, EPCAM)			You	*Family Member	Age of Diagnosis
Yes	No	Do you have a family history of Lynch Syndrome?			
Yes	No	Diagnosed with endometrial cancer at age 50 or younger?			

Revised Bethesda Guidelines			You	*Family Member	Age of Diagnosis
History of colorectal cancer **AND** one of the following:					
Yes	No	Diagnosed at age 50 or younger?			
Yes	No	Presence of synchronous or metachronous Lynch syndrome-associated cancers, regardless of age?			
Yes	No	Diagnosed at age 60 or younger with a colorectal cancer that demonstrates MSI-high histology (tumor-infiltrating lymphocytes), Crohn's-like lymphocytic reaction, mucinous/signet-ring differentiation, or medullary growth pattern?			
Yes	No	One or more first-degree relatives with a Lynch syndrome-associated cancer, with one of the cancers being diagnosed at age 50 or younger?			
Yes	No	Two or more first- or second degree relatives with Lynch syndrome-associated cancers, regardless of age?			

Amsterdam Criteria			You	*Family Member	Age of Diagnosis
At least two close relatives who all have or have had a cancer associated with Lynch syndrome **AND all** of the following criteria must be met:					
Yes	No	One must be a first-degree relative of the other two.			
Yes	No	At least two successive generations must be affected.			
Yes	No	At least one of the cancers should be diagnosed at age 50 or younger.			
Yes	No	Familial adenomatous polyposis (FAP) should be excluded.			
Yes	No	Two or more first- or second degree relatives with Lynch syndrome-associated cancers, regardless of age?			
OR					
Yes	No	Unaffected patient with a close relative who meets any of the above criteria.			
NOTE: Testing unaffected individuals when no affected family member is available should be considered; significant limitations of interpreting test results should be discussed.					

Adenomatous Polypsis (APC and MUTYH) genetic testing:			You	*Family Member	Age of Diagnosis
Yes	No	Family history of a known APC mutation or two (biallelic) MUTYH mutations.			
Yes	No	Personal history of a total of >10 adenomas.			
Yes	No	Personal history of a desmoid tumor.			
Other Polyposis Syndrome Genetic Testing Criteria:					
Yes	No	Personal or family history of multiple GI hamartomatous polyps or serrated polyps.			

Hereditary Breast Cancer Questionnaire

		Hereditary Breast Cancer History	You	*Family Member	Age of Diagnosis
Yes	No	Breast cancer age 50 or younger?			
Yes	No	Ovarian cancer at any age?			
Yes	No	Triple Negative Breast Cancer?			
Yes	No	Are you Ashkenazi Jewish and had either Breast, Ovarian, or Pancreatic Cancer at any age?			
Yes	No	Male Breast Cancer at any age?			
Yes	No	Two or more relatives on the same side of the family with Breast Cancer, Prostate Cancer, or Pancreatic Cancer?			
Yes	No	A relative on the same side of the family that has had both Breast and Ovarian Cancer at any age?			
Yes	No	One relative with Ovarian Cancer and another relative with Breast Cancer at any age on the same side of the family?			
Yes	No	Three or more relatives on the same side of the family with Breast Cancer at any age?			

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Has anyone in your family taken a genetic test in the past? ◻ YES ◻ NO

If yes, which family member(s)? ____

Results (if applicable)? ____

Patient Signature: ____

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Hereditary Colorectal Cancer Testing Recommended?	☐ **Yes**	☐ **No**	
Hereditary Breast Cancer Testing Recommended?	☐ **Yes**	☐ **No**	
Patient Offered Genetic Testing?	☐ **Yes**	☐ **No**	
	☐ **Accepted**	☐ **Declined**	☐ **Informed**
HCP Signature: ____			

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