

Family History Questionnaire

Name: _____

Date of Birth: _____

Your Biological Family	First Name	M or F	Type of Cancer & Age at Diagnosis		Other Significant Illnesses	Age at Death
Ex:	Jane	F	Ovarian Cancer	50	Heart failure	55
Children						
Siblings						
Nieces		F				
		F				
Nephews		M				
		M				
MOTHER'S SIDE OF FAMILY:						
Mother		F				
Grandmother		F				
Grandfather		M				
Aunts/Uncles						
First Cousins						
Great Aunts/Uncles						
Great Grandparent						
FATHER'S SIDE OF FAMILY:						
Father		M				
Grandmother		F				
Grandfather		M				
Aunts/Uncles						
First Cousins						
Great Aunts/Uncles						
Great Grandparent						

Please mark below if *You* currently have, or in the past have had any of the following:

- Ovarian cancer, fallopian tube cancer, or primary peritoneal cancer?
- Pancreatic cancer?
- Metastatic prostate cancer?
- Breast cancer at age 45 or younger?
- Triple negative breast cancer at age ≤60?
- Male with breast cancer?
- Ashkenazi Jewish ancestry?
- *More than one diagnosis of breast cancer in your lifetime?
- *Breast cancer and at least 1 relative with either breast, prostate, ovarian, or pancreatic cancer?
- *Prostate cancer and at least 1 relative with either breast, prostate, ovarian, or pancreatic cancer?
- *Metastatic breast cancer?
- *Family member with colon cancer or endometrial cancer at age 50 or younger?
- *Family member with metastatic prostate cancer?
- *Known cancer gene mutation in you or your family member?