

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ Provider: \_\_\_\_\_

Please mark below if there is a personal or family history of any of the following cancers. If YES, then indicate family relationship and age at diagnosis in the appropriate column. Consider parents, children, brothers/sister, grandparents, aunts/uncles, and cousins.

	<u>YOU</u>	<u>Siblings/children</u>	<u>Mother's side</u>	<u>Father's side</u>
<i>Example: Colorectal cancer</i>		<i>Brother, age 36</i>	<i>Aunt, age 44</i>	<i>Grandfather, age 65</i>
<b>BREAST AND OVARIAN CANCER</b>				
Breast cancer	_____	_____	_____	_____
Ovarian cancer	_____	_____	_____	_____
Breast cancer (both breasts) or multiple primary breast cancers	_____	_____	_____	_____
Male breast cancer	_____	_____	_____	_____
Ashkenazi Jewish descent?	_____	_____	_____	_____
<b>COLON AND UTERINE CANCER</b>				
Uterine (endometrial) cancer	_____	_____	_____	_____
Colorectal cancer	_____	_____	_____	_____
Ovarian, stomach, brain, kidney/urinary tract or small bowel cancer	_____	_____	_____	_____
10 or more cumulative colon Polyps	_____	_____	_____	_____

**Evaluation and action by VOB provider:**

- \_\_\_\_\_ **Patient appropriate for further risk assessment and/or genetic testing**
  - \_\_\_\_\_ BRACAnalysis – A test for Hereditary Breast and Ovarian Cancer
  - \_\_\_\_\_ COLARIS – A test for Lynch Syndrome (Hereditary Nonpolyposis Colorectal Cancer)

\_\_\_\_\_ **Discussed hereditary cancer risk with patient**

\_\_\_\_\_ **Patient offered genetic testing**

- \_\_\_\_\_ **ACCEPTED**
- \_\_\_\_\_ **DECLINED**

\_\_\_\_\_ Provider Date of Service

