Family History Questionaire for Cancer

Date: _____ ☐ Male ☐ Female Age: _____

Referring Physician: _____

Name: _____
(Last, First, Middle Initial)

Contact Numbers:

Day: _____ Evening: _____ Cell: _____

Email: _____

Health History: Please check boxes and total the number of occurrences if there is personal and/or family history of any of the following conditions:

Condition	Patient	Mother's Side	Father's Side	Total
Breast Cancer (prior to age 60)	☐	☐	☐	
Breast Cancer for Male (any age)	☐	☐	☐	
Ovarian Cancer (any age)	☐	☐	☐	
Endometrial Cancer (prior to age 50)	☐	☐	☐	
Colorectal Cancer (prior to age 50)	☐	☐	☐	
Colorectal Polyp (s) (under age 50 or more than 10)	☐	☐	☐	
Melanoma (multiple family members)	☐	☐	☐	
Pancreatic Cancer (any age)	☐	☐	☐	
Eastern European Jewish Ancestry	☐	☐	☐	
Other:	☐	☐	☐	

☐ Physician reviewed history with patient
☐ Patient will follow up with Genetic Counselor; form faxed to 732-776-4902
☐ Patient declined further follow up; form not faxed

Patient Signature: _____ Date: _____

To schedule appointments, please call 732-776-4647 or email, afay@meridianhealth.com or jamurphy@meridianhealth.com

FOR OFFICE USE ONLY/GENETIC COUNSELOR
(Genetic Counselor will fax this information back to physician office)

☐ Patient is appropriate for further risk assessment and/or genetic testing ☐ Yes ☐ No
☐ Information package given to patient for review. Follow up appointment scheduled on: _____
☐ Patient phoned/voicemail left. Date: _____
☐ Patient offered risk assessment: **Accepted** OR **Declined** (circle)
☐ Faxed to physician's office. Date: _____ HCP/Physician Signature: _____