



COMPREHENSIVE  
CANCER CENTERS  
OF NEVADA

### Cancer Family History Questionnaire

Please complete this form to the best of your ability and bring it to your next scheduled visit with your physician. This information will assist your physician in knowing the cancers that may run in your biological (blood related) family. When you complete the table below, please include your information as well as information for your parents, sisters, brothers, sons, daughters, grandparents, aunts, uncles, and first cousins. Please sign the form.

Date Form Completed: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

Cancer Type	Who was/is affected? At what age was the cancer type found? <i>For Example: Dad, 45 years old Mom, 67 years old Son, 56 years old</i>
Ovarian	
Breast	
Uterus	
Colon/rectal	
Prostate	

Are there any other cancers that run in your family?  
\_\_\_\_\_

Are you of Ashkenazi Jewish descent?  YES  NO

Are you of African American descent?  YES  NO

Have you or anyone in your blood related family had 20 or more lifetime colon polyps?  YES  NO

Has anyone in your family had cancer genetic testing? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Are you concerned about your personal and/or family history of cancer? \_\_\_\_\_

**For Healthcare Provider/Staff completion:**

Recommendations:  Refer for Genetic Counseling (*by MD order or physician standing order*).

No Genetic Counseling referral indicated at this time.

