

# Family History Questionnaire for Hereditary Colorectal Cancer Syndromes

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**Instructions:** Please circle N or Y to those that apply to YOU and/or YOUR FAMILY (on both your mother’s and father’s side). After each statement, please list the relationship to you of the individual diagnosed (such as self, paternal uncle, maternal aunt, paternal grandmother) and age at diagnosis. Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary colorectal cancer syndromes; if you circle Y to any of the statements below, you MAY be appropriate for the genetic testing. Ask your healthcare provider for additional information.

	<u>RELATIONSHIP</u>	<u>AGE AT DIAGNOSIS</u>
<b><u>HISTORY</u></b>		
Y N 10 or more colon polyps found in their lifetime	_____	_____
Y N Colorectal cancer before the age of 50	_____	_____
Y N Uterine cancer before the age of 50	_____	_____
Y N Both uterine & colorectal cancer	_____	_____
(in an individual or a family)	_____	_____
Y N 2 or more uterine or colorectal cancers	_____	_____
(in an individual or a family)	_____	_____
Y N Uterine and/or colorectal cancer AND	_____	_____
Ovarian, stomach, kidney/urinary tract, brain	_____	_____
OR small bowel cancer (individual or a family)	_____	_____

<b><u>OTHER FAMILY HISTORY</u></b>		
Y N Esophageal cancer	_____	_____
Y N Stomach cancer	_____	_____
Y N Liver cancer	_____	_____
Y N Crohn’s disease	_____	_____
Y N Ulcerative colitis	_____	_____

\_\_\_\_\_  
Patient’s Signature                      Date

\_\_\_\_\_  
Health Care Provider’s Signature                      Date