

Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: _____ Physician: _____
 Date of Birth: _____ Date Completed: _____

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

*Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins
 Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather*

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 breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Uterine (endometrial) cancer before age 50	_____	_____	_____
Y N Colorectal cancer before age 50	_____	_____	_____
Y N Ovarian, stomach, kidney/urinary tract, brain or small bowel cancer	_____	_____	_____
Y N Two or more Lynch syndrome cancers*	_____	_____	_____

BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Breast cancer at age 50 or younger	_____	_____	_____
Y N Ovarian cancer	_____	_____	_____
Y N Two primary (unrelated) breast cancers in the same person or on the same side of the family	_____	_____	_____
Y N Male breast cancer	_____	_____	_____
Y N Triple negative breast cancer [†] (ER-, PR-, HER2- pathology)	_____	_____	_____
Y N Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family	_____	_____	_____
Y N Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family	_____	_____	_____
Y N Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:	_____	_____	_____

 Patient's Signature Date

FOR OFFICE USE ONLY <input type="checkbox"/> Candidate for further risk assessment and/or genetic testing <input type="checkbox"/> Information given to patient to review <input type="checkbox"/> Follow-up appointment scheduled Date: _____	<input type="checkbox"/> Patient offered genetic testing: <input type="checkbox"/> Accepted <input type="checkbox"/> Declined <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div> <p style="text-align: center; font-size: small;">Healthcare Professional's Signature Date</p>
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*Lynch syndrome-related cancers include ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, sebaceous adenomas
 † For a better understanding of triple negative breast cancer, please ask your healthcare provider.

