CANCER ASSESSMENT RISK EVALUATION

Name: _____ **Your Doctor's Name:** _____

Date of Birth: _____

Gender: M / F **Have you ever been diagnosed with cancer? Yes / No**

Age: _____

	Who Was Diagnosed? *(YOU, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-siblings, First Cousins, Great-grandparents and Great-*	**Maternal** (mother's side) or **Paternal** (father's side)? Mark		**How old were they when they were diagnosed?**	**RED FLAGS (OFFICE USE ONLY)**		
Have YOU or anyone in your family had BREAST CANCER? **[ ] Myself** **[ ] No** **[ ] Family Member (complete this section)** →					**Personal History**	**[ ] Breast cancer dx'd before age 50, including DCIS** **[ ] Ovarian cancer** **[ ] Two primary breast cancers** **[ ] Male breast cancer** **[ ] Triple negative breast cancers** **[ ] Ashkenazi Jewish ancestry with an HBOC assoc. cancer** **[ ] Breast cancer w/ 2+ relatives w/ an HBOC assoc. cancer at any age on same side of family** ***(incl. breast, ovarian, pancreatic, aggressive prostate)***	**HBOC**
Have YOU or anyone in your family had OVARIAN CANCER? **[ ] Myself** **[ ] No** **[ ] Family Member (complete this section)** →					**Family History** (1st, 2nd, or 3rd-degree)	**[ ] Breast cancer before age 50** **[ ] Two primary breast cancers** **[ ] Ovarian cancer** **[ ] Male breast cancer** **[ ] A previously identified HBOC syndrome mutation in the family** **[ ] Three or more HBOC-assoc. cancers at any age on same side of family** ***(incl. breast, ovarian, pancreatic, aggressive prostate)***	
Have YOU or anyone in your family had COLON CANCER (or 10+ colon polyps) (circle one)? **[ ] Myself** **[ ] No** **[ ] Family Member (complete this section)** →					**Personal History**	**[ ] Colorectal or endometrial cancer before age 50** **[ ] MSI High histology before age 60** **[ ] Abnormal tumor test result (colorectal/endometrial) MSI High, IHC absent** **[ ] Two or more Lynch Syndrome cancers at any age** **[ ] Lynch syndrome cancer with one or more relatives w/ a Lynch Syndrome cancer on the same side of the family** **[ ] 10 or more cumulative colorectal adenomas at any age**	**LYNCH**
Have YOU or anyone in your family had any of the following Lynch Syndrome cancers?: ***Pancreatic*** ***Stomach/gastric*** ***Brain*** ***Kidney*** ***Ovarian*** ***Sebaceous adenc*** ***Small bowel*** ***Biliary tract*** ***Endometrial / Uterine*** **[ ] Myself** **[ ] No** **[ ] Family Member (complete this section)** →					**Family History** (1st, 2nd, or 3rd-degree Relative)	**[ ] Previously identified Lynch/MAP mutation in family** **[ ] A first- or second-degree relative with colorectal or endometrial cancer before age 50** **[ ] Two or more relatives with a Lynch syndrome cancer, one before the age of 50 on same side of family** **[ ] Three or more relatives with a Lynch syndrome cancer at any age on the same side of the family** **[ ] A previously identified Lynch syndrome, MAP, AFAP, FAP syndrome mutation in the family** **[ ] One or more relatives with 10 or more cumulative colorectal polyps (adenomas) at any age**	
Have YOU or anyone in your family had any of the following cancers?: ***Melanoma*** ***Sarcoma*** ***ANY Other Cancers*** **[ ] Myself** **[ ] No** **[ ] Family Member (complete this section)** →							**Other**

LANCASTER HEMATOLOGY ONCOLOGY CARE
PERSONALIZED CANCER MEDICINE

Patient offered risk assessment? **YES NO / ACCEPTED DECLINED**

Follow-up appointment scheduled?

Doctor's/Provider's Signature: _____ **Date:** _____ **YES (date:_____) NO**