PREMIER GENOMICS
HEREDITARY CANCER

HEREDITARY CANCER QUESTIONNAIRE

NAME	DATE OF BIRTH
Please complete the below information.	

PERSONAL AND FAMILY HEALTH CONDITIONS

Please ✔ the "yes," box for any health conditions you or your family members have now or have had in the past. Please only consider family members related to you by blood, such as your parents, grandparents, children, brothers/sisters, aunts/uncles, cousins, and nieces/nephews.

	YES	WHO IN YOUR FAMILY AND AT WHAT AGE THEY WERE DIAGNOSED. INCLUDE YOURSELF AND IF APPLICABLE IF FROM MOTHER'S SIDE OR FATHER'S SIDE.
BREAST Cancer diagnosed at any age and **JEWISH** ancestry	☐	
BREAST Cancer diagnosed before age 45	☐	
BILATERAL BREAST Cancer first breast diagnosis before age 50	☐	
3 OR MORE CLOSE BLOOD RELATIVES with **BREAST** Cancer at any age	☐	
MALE Breast Cancer at any age	☐	
OVARIAN Cancer (ovarian, peritoneal, fallopian tube) at any age	☐	
UTERINE Cancer diagnosed before age 50	☐	
COLON or **RECTAL** Cancer diagnosed before age 50	☐	
2 CLOSE BLOOD RELATIVES diagnosed with **COLON, RECTAL, UTERINE, GI**, or **BRAIN CANCER** at least 1 relative diagnosed before age 50	☐	
2 SEPARATE COLON or **RECTAL** Cancers in the same person	☐	
3 or more **CLOSE BLOOD RELATIVES** with **COLON**, Rectal, Uterine, GI, or Brain Cancers	☐	
10 or more colon polyps	☐	
I or someone in my family have had genetic testing for hereditary cancer. If so, which cancer?	☐	

	YOU
I have undergone bone marrow transplant from a donor, peripheral stem cell transplant or have a hematologic cancer or Myelodysplastic Syndrome (MDS).	☐ Yes ☐ No