ADRIATICA
Women's Health
OB/GYN

Hereditary Cancer Risk Assessment

Patient Name:_____ Physician/Provider Name:_____

Date of Birth:_____ Today's Date:_____

Instructions: This is a screening tool for the common features of hereditary cancer syndromes. When you circle Y, **please provide the family member's relationship to you, the site of their cancer and their age** when they were diagnosed with cancer.

Mother / Father / Sister / Brother / Children = 1st Degree Relative; Aunt / Uncle / Grandparent / Niece / Nephew = 2nd Degree

Have you or any of your relatives been tested for hereditary cancer (BRCA or Lynch Syndrome)? Yes No

If YES, were the results positive or negative? Positive Negative

BREAST AND OVARIAN CANCER SYNDROME			SELF (X)	FAMILY MEMBER		Age at Diagnosis
				Mother's Side	Father's Side	
Y	N	One Breast Cancer under 50				
Y	N	One Ovarian Cancer at ANY age				
Y	N	Three relatives on same side of family (maternal or paternal) with either breast, pancreatic or prostate cancer at any age				
Y	N	One relative with TWO separate breast cancers				
Y	N	One Male Breast Cancer at ANY age				
Y	N	A family member with a known BRCA mutation				

LYNCH SYNDROME			SELF (X)	FAMILY MEMBER		Age at Diagnosis
				Mother's Side	Father's Side	
Y	N	One Uterine / Endometrial Cancer under 50				
Y	N	One Colorectal Cancer under 50				
Y	N	Three or more of the following cancers on the same side of the family: Colorectal, Uterine/Endometrial, Stomach, Kidney/Urinary Tract, Pancreas, Ureter/Renal Pelvis, Small Bowel, Brain, Sebaceous Adenoma				
Y	N	A family member with a known Lynch Syndrome mutation				

Are you of Jewish descent? YES NO

Is there any other cancer in you or any family members not provided above? If yes, provide relationship, site of cancer, and age of diagnosis:_____

CANCER RISK ASSESSMENT REVIEW (To be completed after discussion with your healthcare provider)		
Patient's Signature:		Date:
Physician's Signature:		Date:
Office Use Only	Patient offered hereditary cancer genetic testing? Yes No Accepted Declined If yes and accepted, which test? BRACAnalysis with Myriad myRisk ColarisPLUS with Myriad myRisk Myriad myRisk Update Multisite 3 BRACAnalysis REFLEX to BRACAnalysis with Myriad myRisk Single Site Testing Other:_____	

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Interval Gynecological History

Print Name _____ Date of Birth _____ Date _____

1. What is the reason for your visit today? _____
2. Any medication allergies? _____
3. Current medications: _____
4. List any current non-prescription or street drugs: _____
5. Do you drink alcohol? ---------- Y N Type _____ Daily amount _____
6. Do you smoke?---------- Y N Daily amount _____
7. How much caffeine do you consume on a daily basis? _____
8. Please indicate your present method of birth control: _____
9. Are you currently pregnant?----------Y N Maybe
10. What was the first day of your last menstrual period? _____ 11. Do you skip periods?----- Y N
12. Have you noticed anything different about your periods? _____
13. How long is it between the start of one period and the start of the next? _____ Length of period _____
14. Write in the number and size of tampons and/or pads that you use on your "heaviest" day: _____ tampons _____ pads
15. During or between periods, do you have pains and/or pressure in your lower back, abdomen or pelvis?---------- Y N
    If so, please describe: _____
16. Have you had any spotting and/or bleeding between periods?---------- Y N
    If so, please describe: _____
17. Have you noticed any unusual vaginal odor, discharge or itching?---------- Y N
    If so, how long has this been happening? _____ What have you tried to relieve the symptoms? _____
    Describe the problem: _____
18. Do you have any problems with urine leakage?---------- Y N
19. Are you sexually active? Y N Are you worried you might have a sexually transmitted disease? Y N
20. Do you have pain with intercourse?---------- Y N
    If so, please describe: _____
21. Do you examine your breast? Y N Do you have any discharge from your breasts? Y N
    Describe any concerns and/or changes: _____
22. Date of your last Mammogram? _____Where?_____
23. Date of your last Bone Density Test?_____Where?_____
24. Date of your last Colonoscopy?_____Where?_____
25. Since your last visit, have you or anyone in your family had any recent operations, serious illnesses or injuries? Y N
    If so, please describe: _____
26. Are there any other gynecologic or non-gynecologic problems you would like to discuss with me?---------- Y N
    If so, please list: _____
27. Name, address & ph# of preferred pharmacy: _____

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