CHESAPEAKE REGIONAL HEALTHCARE
BREAST CENTER

# *Heredity Cancer Risk Assessment Form*

| GC Consult needed: _____ | Info packet given: _____ |
|---|---|

Patient Name: _____DOB: _____ Referring Physician: _____

Today's Date:_____ Best Phone #_____

**Have you had Genetic Testing? NO / YES If yes when?**_____

## PART 1 – Have YOU been diagnosed with BREAST or OVARIAN cancer?

☐ **YES – Breast Cancer or Ovarian Cancer?** _____ **Age at Diagnosis?** _____
☐ **NO – Please Skip to PART 2 (below)**

| PERSONAL CANCER HISTORY | | | SELF | FAMILY MEMBER | | AGE AT DIAGNOSIS |
|---|---|---|---|---|---|---|
| | | | | MOTHER'S SIDE | FATHER'S SIDE | |
| Y | N | Have YOU had Breast cancer diagnosed at ***age 50 or younger***? | | | | |
| Y | N | Have YOU been diagnosed with "*Triple Negative" Breast Cancer* (ER-, PR-, HER2-) at **age 60 or younger**? | | | | |
| Y | N | Have YOU been diagnosed with Ovarian cancer at ***any age***? | | | | |

## PART 2 – Do you have a FAMILY HISTORY of breast, ovarian, or pancreatic cancer? YES NO

NOTE: Consider BOTH your mother's side and father's side of the family.
This includes: mother, father, sisters, brothers, children, aunts, uncles, grandparents, nieces, and nephews.

| FAMILY CANCER HISTORY | | | SELF | FAMILY MEMBER | | AGE AT DIAGNOSIS |
|---|---|---|---|---|---|---|
| | | | | MOTHER'S SIDE | FATHER'S SIDE | |
| Y | N | A family history of ***ovarian*** cancer at any age? | | | | |
| Y | N | A family history of ***MALE breast cancers*** at any age? | | | | |
| Y | N | A family history of ***breast cancer at age 45*** or younger? | | | | |
| Y | N | A family history of ***two breast cancers*** on the same side of the family one of which was diagnosed at age 50 or younger? | | | | |
| Y | N | A family history with ***3 or more breast cancers*** on the same side of the family diagnosed at any age? (This could include the patient) | | | | |
| Y | N | A family history of ***3 or more breast, ovarian, or pancreatic cancers*** on the same side of the family diagnosed at any age? (This could include the patient) | | | | |
| Y | N | A family history of ***Triple Negative breast cancer*** (ER-, PR-, HER2-) at age 60 or younger? | | | | |
| Y | N | ***Ashkenazi Jewish*** ancestry with at least one person in the family with breast, ovarian or pancreatic cancer at any age? | | | | |

**Patient Signature:** _____

**FOR OFFICE USE ONLY:**

☐ Patient does not require GC Consult
☐ Patient viewed Video and Declines GC Consult – Reason: _____
☐ Patient viewed Video and Accepts GC Consult **Technologist Initials:** _____