Eastside Medical Group
Eastside Surgical Associates

Hereditary Risk Assessment Checklist

Patient Name: _____ **Patient Date of Birth:** _____/_____/_____

1.) Have YOU, our patient, ever been diagnosed with the following?

	YES	NO
Breast Cancer prior to the age of 50	❑	❑
Male Breast Cancer	❑	❑
Breast Cancer (any age) and have Ashkenazi Jewish ancestry	❑	❑
Ovarian Cancer	❑	❑

This is NOT cervical cancer. If you are unsure, your nurse can help you determine this.

2.) THE FOLLOWING QUESTIONS REGARD YOUR FAMILY'S HISTORY. WE ARE ONLY ASKING ABOUT CERTAIN CANCERS. DO NOT CHANGE ANY WORDING BELOW IN ORDER TO ANSWER "YES" TO A QUESTION.

a. YES

❑ I have two or more relatives on the same side of the family with any of the cancers listed below. (Mark what cancers apply, and circle what relatives were affected by only the cancers listed below.)

❑ Breast ❑ Ovarian ❑ Pancreatic

❑ Father's side of the Family: Grandfather, Grandmother, Father, Aunt, Uncle, First Cousin
❑ Mother's side of the Family: Grandfather, Grandmother, Father, Aunt, Uncle, First Cousin
❑ Other: Brother, sister, Daughter, Son, Niece, Nephew

❑ Check here if any of the relatives you marked above were diagnosed prior to the age of 50.

b. YES

❑ I have a blood relative that has been tested positive for the hereditary breast cancer gene.

BY SIGNING BELOW, I CONFIRM THAT I HAVE PROVIDED COMPLETE AND ACCURATE INFORMATION REGARDING MY PERSONAL AND FAMILY HISTORY AS OF THE DATE SIGNED.

_____ _____

PATIENT SIGNATURE **DATE**

FOR OFFICE USE ONLY:

❑ Patient's 2nd primary dx of breast cancer
❑ Bilateral breast cancer
❑ ER+/PR+/HER2+ Breast Cancer (Triple Negative) dx prior to 60 years old

❑ Patient appropriate ❑ Patient not appropriate ❑ Specimen sent to lab on _____

❑ Accepted ❑ Declined

_____
Health Provider Review Date