BEACON
CANCER CARE

Family History – Cancer History Assessment

Patient Name:_ (Last)_______________________ (First) _______________(Initial)_____ **DOB: __/__/__** **MRN:**_____________
Patient's preferred contact number: ________________________ **Physician Name:** _________________ **Date:** ____________

This is a screening tool for cancer that runs in families. When completing the form, please consider the following family:
1st Degree Relatives = Mother/Father/Sister/Brother/Children
2nd Degree Relatives = Aunt/Uncle/Grandmother/Grandfather/Niece/Nephew
3rd Degree Relatives = Cousin/Great Aunt or Uncle/Great Grandparents

Family Relation to you	Male or Female (when applies)	Father or Mother's side of Family	Cancer type: (write in all #s that apply)	Age of Cancer Diagnosis (estimate are OK)	Age of death (when applies)	Does/did this person ever smoke? Yes	No	Has Ever used Alcohol? Yes	No
Example: Cousin	Female	Father's	8	47	75	x			x

Have you or any of your family members had genetic testing for hereditary cancer?
YES NO
<u>If yes and you know the result, please provide your physician a copy of these results.</u>
Are you of Ashkenazi Jewish heritage? YES NO

For Office Use Only:
Genetic counseling is not indicated for patient at this time
Genetic counseling should be considered for this patient
Patient accepted, information sent to genetic counselor (Apt_________________)
Patient declined, reason ____
HCP Signature: ____

Cancer Types:

1. Acute leukemia, AML/ALL
2. Adrenal gland
3. Anus
4. Bile duct
5. Bladder
6. Bone
7. Brain
8. Breast
9. Carcinoid/Neuroendocrine
10. Cervix
11. Chronic leukemia, CML/CLL
12. Colon
13. Desmoid tumor
14. Esophagus
15. Gall bladder
16. GIST
17. Head and neck
18. Kidney
19. Leukemia
20. Liver
21. Lung
22. Lymphoma, Hodgkin's
23. Lymphoma, non-Hodgkin's
24. Melanoma
25. Mesothelioma
26. Multiple myeloma
27. Ovary
28. Pancreas
29. Paraganglioma
30. Penis
31. Pheochromocytoma
32. Prostate
33. Rectum
34. Salivary gland
35. Skin cancer, non-melanoma
36. Stomach
37. Thyroid
38. Thymus
39. Testicle
40. Ureter
41. Uterus
42. Vagina
43. Vulva
44. Other: _______________
45. Unknown type of cancer