SOUTHEAST VALLEY OB/GYN **480-464-2101**
HEREDITARY CANCER RISK ASSESSMENT
PATIENT: _____ DOB: _____

Have YOU been diagnosed with:	**YES**	**NO**
• Breast cancer before age 50?	____	____
• Ovarian cancer at any age?	____	____
• Breast cancer at any age?	____	____
• Colon cancer at any age?	____	____
• Melanoma at any age?	____	____
• Are you of Ashkenazi Jewish Ancestry?	____	____
• Uterine cancer at any age?	____	____

Have any of your FAMILY members been diagnosed with:	**YES**	**NO**
• Breast cancer before age 50?	____	____
• Ovarian cancer at any age?	____	____
• Male breast cancer at any age?	____	____
• Relative with a BRCA mutation?	____	____
• Uterine cancer at any age?	____	____
• Colon cancer before age 50?	____	____
• History of melanoma?	____	____

If any YES boxes are checked, you have a personal or family history suggestive of one of the more common hereditary cancer syndromes and are a candidate for further risk assessment and, if appropriate, genetic testing to determine if a gene change exists.

☐ Candidate for further risk assessment and/or genetic testing. ☐ Patient offered test.
☐ Information given to patient to review. ☐ Accepted ☐ Declined
☐ Follow up appointment scheduled. Date: _____

_____ _____
Patient signature Date Health Care Provider signature Date