

Family History Questionnaire for Risk of Hereditary Breast and Ovarian Cancer

Patient Name: _____ Physician: _____

Date Completed: _____ (Family history information should be updated annually)

Please place a check mark (✓) in the boxes below for yourself and for each family member who has had cancer as indicated.

	Breast Cancer Before Age 50	Ovarian Cancer At Any Age
Yourself		
Mother		
Sister(s)		
Daughter(s)		
<i>Mother's side</i>		
Grandmother		
Aunt(s)		
Cousin(s)		
<i>Father's side</i>		
Grandmother		
Aunt(s)		
Cousin(s)		

Have your physician evaluate your risk for hereditary breast and ovarian cancer if you have:

- Two (2) or more check marks (✓) in the above table, **OR**
- One (1) check mark (✓) in the above table and you are of Ashkenazi Jewish descent, **OR**
- A personal or family history of both breast and ovarian cancer in one individual, **OR**
- Any male relatives with breast cancer at any age

May we contact you for more information, if necessary? Yes No

Address: _____

Phone: _____

For more information: Phone (800) 469-7423 Fax (801) 584-3615 Email helpmed@myriad.com

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Genetic Testing for Hereditary Breast
and Ovarian Cancer Syndrome



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