Gwinnett Surgical Associates
RISK ASSESSMENT FOR HEREDITARY CANCERS
This form is to be filled out only by breast patients.

Patient Name: ______________________________ Date: ____________________
Date of Birth: ____________________ Provider: ________________

Please circle YES or NO as it pertains to YOU and YOUR FAMILY & provide age and explanations if warranted

- Did you have Breast Cancer before the age of 50? YES NO
- Has anyone on your mothers or fathers side of the family have 3 or more Breast Cancers on the same side? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Have you or anyone on your mothers or fathers side of the family have Cancer in both breasts or cancer twice? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Have you or anyone in your family had male Breast Cancer? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Have you or anyone in your family had Ovarian Cancer? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Have you or anyone in your family had Colorectal cancer before the age of 50? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Have you or anyone in your family had Endometrial (Uterine) Cancer before the age of 50? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Have you or anyone in your family had 3 or more Colon, Endometrial, Ovarian, Brain, Gastric, Pancreatic, Small Bowel, Renal/Pelvic Cancer on the same side of the family? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnosis ____________________
- Do you or anyone in your family have Ashkenazi Jewish ancestry with Breast, Ovarian, or Pancreatic Cancer at any age? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnoses ____________________
- Have you ever had Endometrial (Uterine) Cancer? YES NO
  - If you answered yes, please provide AGE of diagnosis _______
- Have you or any member of your family ever been tested for BRAC or Lynch Syndrome? YES NO
  - If you answered yes, please provide whom in your family AND age of diagnoses ____________________

______________________________ Patient Signature

______________ Date

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