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

Patient Name: ____ Provider:__________________________

Date of Birth: _________________________ Today's Date:______________________

Instructions: Please circle YES or NO as they apply to YOU and/or YOUR FAMILY. This includes both parents' sides of the family. This would include any of the following family members: Yourself, Mother/Father, Brother/Sister, Children, Paternal and Maternal Aunt/Uncle, Niece/Nephews, Grandmother/Grandfather.
*If you do not know the exact age of diagnosis for your family member, you may enter your best guess or decade. Example: 50's or 60's

Please circle YES or NO as it pertains to YOU			**Mother or Fathers side of the family?**	**Please use the space below to include which family member and age of diagnosis**
Breast cancer before age 50?	**YES**	**NO**	______________	__________________________
3 or more breast cancers on same side of family	**YES**	**NO**	______________	__________________________
Breast cancer in both breasts or breast cancer twice in the same person	**YES**	**NO**	______________	__________________________
Male breast cancer	**YES**	**NO**	______________	__________________________
Ovarian cancer	**YES**	**NO**	______________	__________________________
Colorectal cancer before age 50	**YES**	**NO**	______________	__________________________
Endometrial (Uterine) cancer before age 50	**YES**	**NO**	______________	__________________________
3 or more Colon, Endometrial, Ovarian, Brain, Gastric, Pancreatic, Small Bowel, Renal/Pelvic cancers on the same side of the family	**YES**	**NO**	______________	__________________________
Ashkenazi Jewish ancestry with a family member With Breast, Ovarian, or Pancreatic Cancer at any age?	**YES**	**NO**	______________	__________________________

Have YOU ever had Endometrial (Uterine) Cancer, regardless of age at diagnosis? **YES** **NO** If yes, what age were you diagnosed? _______

Have you or any member of your family ever been tested for BRAC or Lynch Syndrome? **YES** **NO** If yes, Please explain: _______________________________

Patient Signature

Date