## Caring For Women's Health - Dr. Lori Davidson Family History Questionnaire For Cancer Risk

| Patient Name  | • <u></u>             |  | Today's Date:            |                        | _                   |
|---|-----------------------|--|--------------------------|------------------------|---------------------|
| Physician Name  | •                     |  | Date of Birth:           |                        |                     |
| Is Your Family of Ashker  | nazi Jewish desent?   | YES  | NO                       |                        |                     |
| Please enter the AGE (  | OF CANCER DIAGNOSIS   | S and PRE/POST MEN   | OPAUSAL in the boxe      | s below for yourself A | AND for each family |
|   | mem                   | nber who has been dia  | agnosised with cancer    | •                      |                     |
|   |                       |  |                          | Endometrial            |                     |
|   | <b>Breast Cancer</b>  | <b>Ovarian Cancer</b>  | <b>Colorectal Cancer</b> | (Uterine) Cancer       | Other Cancer        |
|   | (age of diagnosis)    | (age of diagnosis)   | (age of diagnosis)       | (age of diagnosis)     | (age of diagnosis)  |
| Yourself  |                       |  |                          |                        |                     |
| Your Brothers   |                       |  |                          |                        |                     |
| Your Sisters  |                       |  |                          |                        |                     |
| Your Children   |                       |  |                          |                        |                     |
|   |                       | Your MO  | THER's side of           | the family             |                     |
| Your Mother   |                       |  |                          | _                      |                     |
| Your Aunts  |                       |  |                          |                        |                     |
| Your Uncles   |                       |  |                          |                        |                     |
| Your Cousins  |                       |  |                          |                        |                     |
| Your Grandparents   |                       |  |                          |                        |                     |
|   |                       | Your FAT   | HER's side of t          | he family              |                     |
| Your Father   |                       |  |                          |                        |                     |
| Your Aunts  |                       |  |                          |                        |                     |
| Your Uncles   |                       |  |                          |                        |                     |
| Your Cousins  |                       |  |                          |                        |                     |
| Your Grandparents   |                       |  |                          |                        |                     |
|   | ☐ Patient appropriate | Patient appropriate for further risk assessment and/or genetic testing |                          |                        |                     |
| ☐ Patient recommended for genetic testing ☐ Accepted ☐ Rejected |                       |  |                          |                        |                     |
| Patientn Signature:   | Date:                 |  | Healthcare Provider Sig  | gnature Date:          | -                   |