natera™ | Empower™ Hereditary cancer test

TODAY'S DATE:	NAME:	AGE:	DATE OF BIRTH:

Family History Questionnaire

Please answer the following questions to the best of your knowledge to help your care team understand cancer patterns in your family. For more information, text EMPOWER to 484848.

Select Yes/No and enter information in the accompanying boxes of the same row. Family members include parents, siblings, children, uncles, aunts, first cousins, grandparents, grandchildren, nieces, nephews, or half-siblings.

Please complete the following for you and your family members:		Age at diagnosis	Enter family member and age at diagnosis		
		You	Siblings/Children	Mother's side	Father's side
Example: Breast cancer	☒ Y ☐ N	Age 46	Daughter, 23 Sister, 52	Aunt, #1 63 Aunt, #2 48	Grandma, 81
1. Breast cancer < age 50	☐ Y ☐ N				
2. Either colon cancer or uterine cancer < age 50	☐ Y ☐ N				
3. Triple negative breast cancer ≤ age 60	☐ Y ☐ N				
4. Two or more breast cancers in the same person (first diagnosis ≤ age 50)	☐ Y ☐ N				
5. Two or more colon and/or uterine cancers in the same person	☐ Y ☐ N				
6. Two family members with breast, colon or uterine cancer (one ≤ age 50)	☐ Y ☐ N				
7. Three or more family members from the same side with breast cancer	☐ Y ☐ N				
8. Three or more family members with colon and/or uterine cancer	☐ Y ☐ N				
9. Ovarian cancer Pancreatic cancer Male breast cancer 10 or more precancerous colorectal polyps	☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N ☐ Y ☐ N				
10. Ashkenazi Jewish **AND** breast cancer or prostate cancer	☐ Y ☐ N				
11. You or a close family member has a known gene mutation. Please list _____	☐ Y ☐ N				
12. Other cancers not listed above _____	☐ Y ☐ N				
13. Other concern about your cancer risk	☐ Y ☐ N	Please explain:			

If you have never been diagnosed with breast cancer, please complete the following questions.

1. Height (ft/in) _____ **2.** Weight (lbs) _____ **3.** Have you had children? ☐**Y** ☐**N** How old were you when you had your first child? _____

4. Approximate age at first menstrual period? _____ **5.** Have you gone through menopause? ☐**Y** ☐**N** ☐**Ongoing** If yes, at approximately what age? _____

6. Are you of Ashkenazi Jewish descent? ☐**Y** ☐**N** ☐**I don't know**

7. Have you ever used hormone replacement therapy? ☐**Y** ☐**N** ☐**Ongoing** If yes, when? Start date _____ End date _____

If yes, what type? ☐ **Estrogen** ☐ **Progesterone** ☐ **Combined** ☐ **I don't know**

8. How many sisters do you have? ____ Daughters? ____ Maternal aunts? ____ Paternal aunts? ____ Maternal half-sisters? ____ Paternal half-sisters? ____

9. Have you ever had a breast biopsy? ☐**Y** ☐**N** If yes, what was the result? ☐ **Hyperplasia** ☐ **Atypical hyperplasia** ☐ **LCIS** ☐ **I don't know**

Signatures

Patient Name	**Patient Signature**	**Date**
Provider Name	**Provider Signature**	**Date**

For Office Use Only

A 'Yes' answer to any of questions 1–11 indicates your patient may meet criteria for hereditary cancer testing.

Patient offered hereditary cancer genetic testing
(check all that apply)

☐ **Yes** ☐ **No** ☐ **Patient accepted** ☐ **Patient declined**

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