**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<br>Sister, 52 | Aunt, #1 63<br>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<br>Pancreatic cancer<br>Male breast cancer<br>10 or more precancerous colorectal polyps | ☐ Y ☐ N<br>☐ Y ☐ N<br>☐ Y ☐ N<br>☐ 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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