

## Risk Assessment for Lynch Syndrome and Hereditary Breast and Ovarian Cancer Syndrome

Patient Name: \_\_\_\_\_ Physician: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Instructions: Please circle Y for those that apply to YOU and/or YOUR FAMILY (on both your mother's/maternal or father's/paternal side). Next to each statement, please list the relationship to you and age of diagnosis. You and the following family members should be considered:

*Mother Father Brother Sister Children Paternal Uncle/Aunt Maternal Uncle/Aunt First Cousins  
 Niece/Nephew Maternal Grandmother/Grandfather Paternal Grandmother/Grandfather*

Each statement should be answered individually, so you may list the same cancer diagnosis more than once as you answer these questions. This is a screening tool for the common features of hereditary breast and ovarian cancer syndrome and Lynch syndrome. Share this information with your healthcare professional to help determine your hereditary cancer risk.

COLON AND UTERINE CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Uterine (endometrial) cancer before age 50			
Y N Colorectal cancer before age 50			
Y N Two or more Lynch syndrome cancers* in the same person or on the same side of the family			

(\*Lynch syndrome cancers include: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain or sebaceous adenomas)

BREAST AND OVARIAN CANCER	SELF	FAMILY MEMBER	AGE AT DIAGNOSIS
Y N Breast cancer at age 50 or younger			
Y N Ovarian cancer			
Y N Two primary (unrelated) breast cancers in the same person or on the same side of the family			
Y N Male breast cancer			
Y N Triple negative breast cancer <sup>†</sup> (ER-, PR-, HER2- pathology)			
Y N Pancreatic cancer with breast or ovarian cancer in the same person or on the same side of the family			
Y N Ashkenazi Jewish ancestry with breast, ovarian or pancreatic cancer in the same person or on the same side of the family			
Y N Have you or any member of your family ever been tested for hereditary risk of cancer? If yes, please explain:			

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>		<input type="checkbox"/> Patient offered genetic testing:
<input type="checkbox"/> Candidate for further risk assessment and/or genetic testing: <input type="checkbox"/> Lynch <input type="checkbox"/> HBOC	<input type="checkbox"/> Accepted	
<input type="checkbox"/> Information given to patient to review	<input type="checkbox"/> Declined	
<input type="checkbox"/> Follow-up appointment scheduled Date: _____	Healthcare Professional's Signature _____	Date _____

<sup>†</sup> For a better understanding of triple negative breast cancer, please ask your healthcare provider. Assessment criteria based on medical society guidelines. For these individuals society guidelines go to [www.myriadtests.com/patient\\_guidelines](http://www.myriadtests.com/patient_guidelines). Myriad, and the Myriad logo are either trademarks or registered trademarks of Myriad Genetics, Inc, in the United States and other jurisdictions. ©2011

