FLORIDA GYNECOLOGIC ONCOLOGY
CANCER HISTORY

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Name: _____ Date: _____

Please fill in the check boxes below for yourself and for each family member who has colon, endometrial, breast or ovarian cancer. Age refers to you or your family's age when cancer was diagnosed.

	Type of cancer	Age at Diagnosis
YOURSELF		
Mother		
Father		
Sister(s)		
Brother(s)		
Daughter(s)		
Son(s)		
MATERNAL SIDE		
Grandmother		
Grandfather		
Aunt(s)		
Uncle(s)		
Cousin(s)		
PATERNAL SIDE		
Grandmother		
Grandfather		
Aunt(s)		
Uncle(s)		
Cousin(s)		

Are you of Ashkenazi Jewish Descent? ❑ Yes ❑ No
Do you have male relatives with breast cancer? ❑ Yes ❑ No

Consider further evaluation for hereditary cancer syndrome if:

- Colon or endometrial cancer diagnosed before age 50
- Two first degree relatives with colon or endometrial cancer at any age
- Two or more tumors in the same individual (colon and/or endometrial cancer)
- Two or more relatives with breast cancer before age 50
- Ashkenazi Jewish descent and any cases of breast cancer before age 50 or ovarian cancer at any age
- Any male relative with breast cancer