BLOOM OB/GYN

CANCER HISTORY FORM

Name: _____ Date of Birth:_____ Today's Date: _____

Have you or a family member ever had screening for genes that cause cancer?

☐ **No** ☐ **Yes** If yes, type of test and year (estimate):_____

Result: ☐ Negative ☐ Positive, Gene:_____

Have you ever been diagnosed with breast cancer, uterine cancer or colon cancer?

☐ **No** ☐ **Yes** If yes, age of diagnosis: _____

Limited To Only The Following:

Parents, Siblings, Children, Grandparents, Aunts/Uncles, Nieces/Nephews

If you circle 'Yes' in the boxes below - designate who the relative is and age of diagnosis

CANCER HISTORY			Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No ◯	Yes ◯	Breast cancer diagnosed **BEFORE AGE 50**				
No ◯	Yes ◯	Ovarian cancer				
No ◯	Yes ◯	Ashkenazi Jewish ancestry with breast or pancreatic cancer				
No ◯	Yes ◯	**3 OR MORE** breast, prostate, or pancreatic cancers on **same** family side				
No ◯	Yes ◯	Male breast cancer				
No ◯	Yes ◯	**3 OR MORE** colon **and/or** uterine cancers on **same** family side				
No ◯	Yes ◯	Pancreatic Cancer (Parents, Siblings or Children)				

OFFICE USE ONLY

Patient offered genetic testing: Yes / No Accepted / Declined / Informed Provider Initials: