ADRIATICA
Women's Health
OB/GYN

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

Patient Name: _____ Physician/Provider Name: _____

Date of Birth: _____ Today's Date: _____

Instructions: This is a screen tool for the common features of hereditary cancer syndromes. If you circle Y (yes) for any statement below, you may be appropriate for hereditary cancer testing. When you circle **Y, please provide the family member's relationship to you, the site of their cancer and their age** when they were diagnosed with cancer.

Mother/ Father/ Sister/ Brother/ Children = 1st Degree Relatives; Aunt/Uncle/Grandparent/Niece/Nephew = 2nd Degree Relatives, Cousin/Great Grandparent = 3rd Degree Relatives

Have you or any of your relatives been tested for hereditary cancer (BRCAnalysis or Lynch/COLARIS)? *YES* *NO*

If YES were the results positive or negative? _____

BREAST AND OVARIAN CANCER			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Breast Cancer at 45 or younger (in self, first or second degree family members)				
Y	N	Ovarian Cancer any age (in self, first or second degree family members)				
Y	N	Two relatives on the same side of the family with breast cancer under the age of 50 (in self, first or second degree family members)				
Y	N	Three relatives on the same side of the family with breast and/or ovarian cancer at any age				
Y	N	One relative with TWO separate breast cancers; one diagnosed before age 50				
Y	N	Triple Negative Breast Cancer under age 60 (receptor status negative for ER, PR, HER				
Y	N	Male breast cancer at any age				
Y	N	Breast or ovarian cancer at any age in Ashkenazi Jewish family members				
Y	N	Pancreatic cancer with 2 or more breast and/or ovarian cancers on same side of family				
Y	N	A family member with a known BRCA mutation				

COLON AND UTERINE CANCER			SELF	FAMILY MEMBER		AGE AT DIAGNOSIS
				MOTHER'S SIDE	FATHER'S SIDE	
Y	N	Uterine (endometrial) Cancer before age 50				
Y	N	Colorectal Cancer before age 50				
Y	N	A family member with a known Lynch Syndrome mutation				
Y	N	Two or more (at any age) of the following cancers on the same side of the family: colorectal, uterine/endometrial, ovarian, stomach, ureter/renal pelvis, kidney/urinary tract, small bowel, pancreas, brain, sebaceous adenoma)				

Are you of Jewish descent: YES NO

Is there any other cancer in you or any family members not provided above? If yes, provide relationship, site of cancer, and age of diagnosis: _____

Patient's signature: _____ **Date:** _____

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Interval Gynecological History

Print Name _____ Date of Birth _____ Date _____

1. What is the reason for your visit today? _____
2. Any medication allergies? _____
3. Current medications: _____
4. List any current non-prescription or street drugs: _____
5. Do you drink alcohol? ---------- Y N Type _____ Daily amount _____
6. Do you smoke?---------- Y N Daily amount _____
7. How much caffeine do you consume on a daily basis? _____
8. Please indicate your present method of birth control: _____
9. Are you currently pregnant?----------Y N Maybe
10. What was the first day of your last menstrual period? _____ 11. Do you skip periods?----- Y N
12. Have you noticed anything different about your periods? _____
13. How long is it between the start of one period and the start of the next? _____ Length of period _____
14. Write in the number and size of tampons and/or pads that you use on your "heaviest" day: _____ tampons _____ pads
15. During or between periods, do you have pains and/or pressure in your lower back, abdomen or pelvis?---------- Y N
    If so, please describe: _____
16. Have you had any spotting and/or bleeding between periods?---------- Y N
    If so, please describe: _____
17. Have you noticed any unusual vaginal odor, discharge or itching?---------- Y N
    If so, how long has this been happening? _____ What have you tried to relieve the symptoms? _____
    Describe the problem: _____
18. Do you have any problems with urine leakage?---------- Y N
19. Are you sexually active? Y N Are you worried you might have a sexually transmitted disease? Y N
20. Do you have pain with intercourse?---------- Y N
    If so, please describe: _____
21. Do you examine your breast? Y N Do you have any discharge from your breasts? Y N
    Describe any concerns and/or changes: _____
22. Date of your last Mammogram? _____Where?_____
23. Date of your last Bone Density Test?_____Where?_____
24. Date of your last Colonoscopy?_____Where?_____
25. Since your last visit, have you or anyone in your family had any recent operations, serious illnesses or injuries? Y N
    If so, please describe: _____
26. Are there any other gynecologic or non-gynecologic problems you would like to discuss with me?---------- Y N
    If so, please list: _____
27. Name, address & ph# of preferred pharmacy: _____

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