



Pre-Endoscopy Family History Questionnaire Hereditary Colorectal Cancer Initiative

DATE	
YOUR NAME	
YOUR CURRENT AGE	
YOUR PRIMARY CARE PHYSICIAN (PCP)	

Are you adopted and do not know your family history? Yes
 Are you of Ashkenazi Jewish descent? Yes No Do not know

How many sisters do you have?		How many brothers do you have?	
How many daughters do you have?		How many sons do you have?	

Do you have a family history of cancer? Please consider all relatives including mother, father, sisters, brothers, sons and daughters as well as maternal and paternal grandparents, aunts and uncles, nieces and nephews. Please record in the following charts to the best of your knowledge those individuals who have had any of the following cancers. Use a second chart if necessary.

	CANCER TYPE	SELF	AGE at DIAGNOSIS	RELATIVE	AGE at DIAGNOSIS
<input type="checkbox"/>	COLON or RECTAL CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	UTERINE (endometrial) CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	OVARIAN CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	STOMACH (gastric) CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	SMALL BOWEL CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	KIDNEY OR BLADDER CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	GALL BLADDER CANCER	<input type="checkbox"/>			
<input type="checkbox"/>	BREAST CANCER including male	<input type="checkbox"/>			
<input type="checkbox"/>	POLYPS (especially 10 or more)	<input type="checkbox"/>			
<input type="checkbox"/>	OTHER CANCERS				
	<input type="checkbox"/> PROSTATE	<input type="checkbox"/>			
	<input type="checkbox"/> PANCREATIC	<input type="checkbox"/>			
	<input type="checkbox"/> BRAIN CANCER	<input type="checkbox"/>			
	<input type="checkbox"/> OTHER	<input type="checkbox"/>			

I wish to be contacted by the Summa Health Systems Colorectal Cancer Coordinator to receive more information concerning Hereditary Colorectal Cancer

Signature

For Endoscopy Use Only	PATIENT INFORMATION LABEL
<input type="checkbox"/> Biopsy performed	
<input type="checkbox"/> Polyp	
<input type="checkbox"/> Suspected tumor	
<input type="checkbox"/> Polyps removed	