For Patients with Commercial Insurance, Medicaid, or Medicare with a secondary plan

Personal & Family Cancer History

Name: _____ Date: _____ Date of Birth: _____ Age: _____

If you have the following insurance, call for information on coverage before moving forward with cancer genetic testing:
☐ *Medicare with no secondary insurance*

Complete the section below. Include **yourself and all 1st and 2nd degree male and female blood relatives on both your mother's and father's sides**. Specify which relatives were affected and estimate ages of diagnosis to the best of your ability.

1st Degree Relatives: **Parents, Siblings, Children**
2nd Degree Relatives: **Grandparents, Aunts/Uncles, Nieces/Nephews**

CANCER HISTORY			You	Siblings/ Children	Mother's Side	Father's Side	Age of Diagnosis
No	**Yes**	BREAST CANCER diagnosed age 49 or younger					
No	**Yes**	OVARIAN CANCER					
No	**Yes**	Ashkenazi Jewish heritage with a BREAST CANCER at any age					
No	**Yes**	3 or more BREAST, PROSTATE, and/or PANCREATIC CANCERS on one family side, any ages					
No	**Yes**	MALE BREAST CANCER					
No	**Yes**	2 or more COLON CANCERS on a family side, at least one under 50					
No	**Yes**	3 or more COLON or UTERINE CANCERS on a family side, any ages					

Patient Signature _____

OFFICE USE ONLY Patient offered genetic testing: Yes / No Accepted / Declined Provider Initials: _____