Ambry Genetics®

Hereditary Cancer Questionnaire

(to be completed by patients)

PATIENT NAME	
DATE OF BIRTH	**TODAY'S DATE**

Instructions: This is a screening tool to help your healthcare provider determine if you would benefit from hereditary cancer genetic testing. Your healthcare provider will review this form looking for any risk factors for a hereditary cancer syndrome such as similar types of cancer running in the family, cancers diagnosed at young ages, or multiple cancer diagnoses in the same person. You may also use the "My Family History" tool to complete this information online at patients.ambrygen.com/cancer.

DOES CANCER RUN IN YOUR FAMILY? Check those that apply.

Please fill this form out to the best of your ability. Please only consider family members related to you **by blood**, such as your parents, grandparents, children, brothers, sisters, aunts, uncles, and cousins. If you share only one parent with a brother or sister, **please indicate that.**

TYPE OF CANCER/ TUMORS	YOURSELF/PARENTS/ BROTHERS/ SISTERS/CHILDREN	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (MOTHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)	EXTENDED FAMILY (FATHER'S SIDE) Aunts/Uncles/Cousins/ Grandparents /Other	AGE AT DIAGNOSIS (estimates are OK)
☑ EXAMPLE: Colorectal Cancer	Me	42			Aunt Uncle	46 55
☐ BREAST CANCER (in women or men)						
☐ OVARIAN CANCER (peritoneal/ Fallopian tube)						
☐ UTERINE (ENDOMETRIAL) CANCER						
☐ COLORECTAL CANCER						
☐ PANCREATIC CANCER						
☐ PROSTATE CANCER						
☐ KIDNEY (RENAL) CANCER						
☐ MELANOMA						
☐ BRAIN TUMOR Type: _____						
☐ OTHER CANCER Type: _____						
☐ MORE THAN 10 COLORECTAL POLYPS (indicate how many)						

☐ No personal or family history of cancer

☐ My family's heritage is Ashkenazi Jewish (an ethnic background that may have a higher likelihood of hereditary cancer)

☐ I, or someone in my family, have had genetic testing for a hereditary cancer syndrome.
(Please describe and provide a copy of test result if possible)

_____

_____

Possible Genetic Testing Indications and Testing Options*

(to be completed by healthcare provider)

PATIENT'S PERSONAL & FAMILY HISTORY** (If any box is checked based on the reverse page, your patient may be an appropriate candidate for genetic testing)	If you/your patient are interested in a multigene panel with ONLY genes that have **published medical management guidelines:**	If you/your patient are interested in a multigene, **tumor-specific panel** including genes that may or may not have published management guidelines:	If you/your patient are interested in a multigene, **comprehensive panel** addressing multiple cancer types including genes that may or may not have published management guidelines:
Hereditary Breast Cancer			
(Please refer to Ambry's HBOC Decision Tree for further details regarding choosing the best test for your patient)			
☐ Early onset breast cancer (≤45y)	BRCAplus	BreastNext	CancerNext
☐ Breast cancer in an Ashkenazi Jewish individual, triple negative breast cancer ≤60y, or breast cancer in a man			
☐ Multiple close family members with breast and/or other cancers^			
Hereditary Gynecologic Cancer			
(Please refer to Ambry's HBOC and/or Colorectal Cancer Decision Tree for further details regarding choosing the best test for your patient)			
☐ Ovarian, Fallopian tube, or primary peritoneal cancer at any age	GYNplus	OvaNext	CancerNext
☐ Uterine cancer <50y or with abnormal MSI/IHC			
☐ Multiple close family members with ovarian or uterine, and other cancers^			
Hereditary Colorectal Cancer			
(Please refer to Ambry's Colorectal Cancer Decision Tree for further details regarding choosing the best test for your patient)			
☐ >10 colorectal polyps in an individual	ColoNext		CancerNext
☐ Colorectal cancer <50y or with abnormal MSI/IHC			
☐ Multiple close family members with colon, uterine, ovarian, and/or stomach cancer^			
Hereditary Prostate Cancer			
☐ Prostate cancer ≤50y		ProstateNext	CancerNext
☐ Metastatic prostate cancer at any age			
Hereditary Kidney Cancer			
☐ Kidney cancer ≤46y OR multiple primary kidney cancers		RenalNext	CancerNext-*Expanded*
☐ Multiple close family members with kidney or other cancers^			
Other Hereditary Cancers			
☐ Brain tumor(s) ≤50y OR multiple close family members with brain tumors and other cancers/ tumors^		BrainTumorNext	CancerNext-*Expanded*
☐ Pheochromocytoma or paraganglioma at any age		PGLNext	CancerNext-*Expanded*
☐ Diffuse gastric cancer (<40y, 2 cases at any age, or with lobular breast cancer - 1 <50y)	BRCAplus, ColoNext		CancerNext
☐ Personal history of multiple primary melanomas OR multiple close family members with melanoma and other cancers^ (*i.e.* pancreatic, renal)		MelanomaNext	CancerNext
☐ Pancreatic cancer <60y OR multiple close family members with pancreatic and/or other cancers^		PancNext	CancerNext

** This is a suggested list; not comprehensive. There are other situations where genetic testing may be appropriate. Details about other genes/tests, including single syndrome testing options and CustomNext-Cancer, are available at ambrygen.com.*

*** If your patient lists a personal history of multiple primary cancers including, but not limited to the cancers/tumors on this list, genetic testing may be indicated.*

^ On the same side of the family.

15 Argonaut, Aliso Viejo, CA 92656 USA Toll Free +1.866.262.7943 Fax +1.949.900.5501 ambrygen.com