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

Hereditary Cancer Questionnaire

(to be completed by patients)

Instructions: This screening tool helps your healthcare provider assess whether you may benefit from hereditary cancer genetic testing by identifying risk factors such as family patterns of cancer, early-onset cancers, rare cancers, or multiple cancers in one person/side of the family.

1. Have YOU previously had genetic testing for hereditary cancer? ☐ Yes ☐ No

If yes, what is the approx. year you were tested?_____ **Result:** ☐ Positive ☐ Negative ☐ Unknown

Instructions: **Please check YES** or **NO** to any statement below as it applies to **YOU** and/or **YOUR 1st, 2nd or 3rd DEGREE RELATIVES.** Next to each statement, please list the applicable **RELATIVE(S), CANCER TYPE(S),** and **AGE AT DIAGNOSIS.**

- **1st Degree Relatives** = Mother / Father / Sister / Brother / Children
- **2nd Degree Relatives** = Aunt / Uncle / Grandparent / Niece / Nephew
- **3rd Degree Relatives** = First Cousins / Great Grandparents

2. YES	NO	CANCER HISTORY	You, brothers/sisters, children	MOTHER'S SIDE (mother, aunt/ uncle, grandparent)	FATHER'S SIDE (father, aunt uncle, grandparent)
☑	☐	**EXAMPLE:** Three family members with **COLON, UTERINE, STOMACH,** or **SMALL INTESTINE** cancer *on the same side* of your family	Me – Uterine (57)	Grandmother – Uterine (61)	Uncle – Colon (66)
☐	☐	**BREAST** cancer at age 50 or younger, *or* three **BREAST** cancers at any age *on the same side* of your family			
☐	☐	Two different cancers *in the same person* (e.g. **BREAST** *and* **OVARIAN, COLON** *and* **UTERINE**)			
☐	☐	Triple negative **BREAST** cancer at any age			
☐	☐	**BREAST** or **PROSTATE** cancer at any age *and* Ashkenazi Jewish ancestry			
☐	☐	Male **BREAST** cancer at any age			
☐	☐	**OVARIAN** cancer at any age			
☐	☐	**PANCREATIC** cancer at any age			
☐	☐	High grade or metastatic **PROSTATE** cancer at any age			
☐	☐	Three or more **BREAST** and/or **PROSTATE** cancers at any age *on the same side* of your family			
☐	☐	**UTERINE** or **ENDOMETRIAL** cancer under the age of 50			
☐	☐	**COLORECTAL** cancer under the age of 50			
☐	☐	*Personal* history of **COLON, UTERINE, SMALL INTESTINE,** or **STOMACH** cancer *and family* history of **COLON, UTERINE, SMALL INTESTINE,** or **STOMACH** cancer under 50			
☐	☐	Three family members with **COLON, UTERINE, STOMACH,** or **SMALL INTESTINE** cancer *on the same side* of your family			
☐	☐	Ten or more **COLORECTAL** polyps (adenomas)			
☐	☐	If anyone in your family has had genetic testing for hereditary cancer and tested positive, list them here.			
☐	☐	If you have a family history of any **OTHER** cancers, list them here.			

*This is a suggested list of genetic testing criteria and is not comprehensive. There are other situations where genetic testing may be appropriate.

If you checked "YES" for any of the questions above, you may benefit from genetic testing. To learn more, return this form to your healthcare provider and scan the QR code on the reverse side for educational resources.

FOR OFFICE USE ONLY:

If the patient answered "Yes" to any of the above questions, they may be eligible for hereditary cancer testing.

Offered the patient hereditary cancer testing: ☐ Yes ☐ No

If YES, did the patient agree to move forward with the testing? ☐ Yes ☐ No (If no, reason:_____)

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Hereditary Cancer Testing with Ambry Genetics

Better understand your risks. Make proactive plans for the future.

Scan here to learn more about hereditary cancer and genetic testing:

Frequently Asked Questions
Short Educational Videos
Patient Guides (English and Spanish)

On The Other Side

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MKT-ONCO-FLYR-20075-EN v15 10.08.25