

Name _____

Address _____

Phone _____ Your Physician _____

1. Check each box for you or your family member who has had cancer. Also, indicate any other cancers.

	Breast Cancer before age 50		Ovarian Cancer at any age		Any other cancer	
Yourself	yes	no	yes	no	yes	no
Mother	yes	no	yes	no	yes	no
Sister	yes	no	yes	no	yes	no
Daughter	yes	no	yes	no	yes	no
Mother's side						
Grandmother	yes	no	yes	no	yes	no
Aunt	yes	no	yes	no	yes	no
Cousin	yes	no	yes	no	yes	no
Others (specify)	yes	no	yes	no	yes	no
Father's side						
Grandmother	yes	no	yes	no	yes	no
Aunt	yes	no	yes	no	yes	no
Cousin	yes	no	yes	no	yes	no
Others	yes	no	yes	no	yes	no

2. Add up your checks. If you have 2 or more yes checks in the "Breast Cancer before age 50" and/or "Ovarian Cancer at any age" columns, you may be a candidate for genetic susceptibility testing for breast and ovarian cancer.

3. Print out and give this completed form to your physician. He or she may refer you to our Genetics Clinic.