

Family History Questionnaire for Common Hereditary Colon Cancer Syndromes

New Patients: Please mark below if there is a *personal or family history* of any of the following cancers. If yes, then indicate family relationship and *age of diagnosis* in the appropriate column. Consider parents, children, brothers, sisters, grandparents, aunts, uncles and cousins.

Established Patients: Please mark below if your personal or family history has changes since your last appointment. If there has been no change please return this form to the secretary.

| | You | Siblings/Children | Mother's Side | Father's Side |
|------------------------------------|------------|--------------------------|----------------------|----------------------|
| Polyps greater than 10 | | | | |
| Colon Cancer | | | | |
| Rectal Cancer | | | | |
| Uterine (Endometrial Cancer) | | | | |
| Gastric (Stomach Cancer) | | | | |
| Thyroid Cancer | | | | |
| Other | | | | |