



**Genetic Risk Evaluation and Testing Program**

Your Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Your physician: \_\_\_\_\_ Your daytime phone number: \_\_\_\_\_

Most cancers happen by chance and are not passed through families. In some families, cancer may be due to genetic factors that are passed from parent to child. Identifying these hereditary families can help determine the risk of cancer for individuals and their close relatives. If you are interested in learning if you may be at risk, please check the boxes below that apply to you or your close family members\*.

*\*Close family members include siblings, parents, children, grandparents, aunts, uncles and first cousins*

Cancer type	YOU		Mother's side of family		Father's side of family	
	YES	NO	YES	NO	YES	NO
Breast cancer before age 50?						
Two different breast cancers?						
Ovarian cancer at any age?						
Male breast cancer at any age?						
Colon cancer before age 50?						
Two different colon cancers?						
Uterine cancer before age 50?						
Two or more Melanomas?						
Stomach cancer?						
Pancreatic cancer?						

Do you have Ashkenazi (Central/Eastern European) Jewish Ancestry?  Yes  No  Don't know

**If any of the above boxes are checked YES, then you may be a candidate for Genetic Risk Evaluation and possibly testing.**

**Patient, please type your name and the date. "I give my permission for the St. Charles Cancer Center Genetic Risk Evaluation and Testing Program to contact me or my physician regarding Risk Evaluation."**

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Patient Name

Date

**Please send this completed form to Janice Poole via email: [jmpoole@stcharleshealthcare.org](mailto:jmpoole@stcharleshealthcare.org) or fax to 541-598-3490.**

**A follow up phone call will be made to discuss the questionnaire and possibly schedule you for a consultation.**