MYRIAD myRisk Hereditary Cancer

Cancer Family History Questionnaire

Personal Information			
Patient Name	Date of Birth	Healthcare Provider	Today's Date

Instructions: Your personal and family history of cancer is important to provide you with the best care possible. Please complete the chart below based upon your personal and family history of cancer. Leave blank what you do not know. The following relatives should be considered: Parents, siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

If you can answer YES to ANY of the questions below, please text 'CRA' to 99150 to watch a short educational video prior to seeing your provider today.

Do you have a personal history of:	Yes (Y) or No (N)?	Which cancer?	Age at diagnosis?
Breast, ovarian, or pancreatic cancer at any age	☐ Y ☐ N		
Colorectal or uterine cancer at 64 or younger	☐ Y ☐ N		

Do you have a family history of:	Yes (Y) or No (N)?	Which relative?	Maternal (M) or Paternal (P) side of the family?	Age at diagnosis?
Breast cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Two breast cancers (bilateral) in one relative at any age	☐ Y ☐ N		☐ M ☐ P	
Three breast cancers in relatives on the same side of the family at any age	☐ Y ☐ N		☐ M ☐ P	
Ovarian cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Pancreatic cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Male breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Metastatic prostate cancer at any age	☐ Y ☐ N		☐ M ☐ P	
Colon cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Uterine cancer at 49 or younger	☐ Y ☐ N		☐ M ☐ P	
Ashkenazi Jewish ancestry with breast cancer at any age	☐ Y ☐ N		☐ M ☐ P	
If you have a family history of any other cancers, list them here:				
Have you or anyone in your family had genetic testing for hereditary cancer?	☐ Y ☐ N	Who?	What gene(s)?	What was the result?

Cancer Risk Assessment Review (to be completed after discussion with your healthcare provider)

Patient Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

Office Use Only Patient offered hereditary cancer genetic testing? ☐ Yes ☐ No ☐ Accepted ☐ Declined

If yes, which test? ☐ BRACAnalysis® with Myriad myRisk® ☐ Multisite 3 BRACAnalysis® REFLEX to BRACAnalysis® with Myriad myRisk®
☐ COLARIS™PLUS with Myriad myRisk® ☐ COLARIS AP™PLUS with Myriad myRisk® ☐ Single Site Testing ☐ Myriad myRisk® Update
☐ Other: _____

Follow-up appointment scheduled? ☐ Yes ☐ No Date of next appointment: _____

David Lubetkin, MD

Courtney McMillian, CNM

Polina Goldenberg, CNM

1001 NW 13th Street, Suite 101A

Boca Raton, FL 33486

Consent for Pelvic Examination

Patient Name _____

DOB _____

I hereby request and authorize David Lubetkin, MD; Courtney McMillian, CNM; and/or Polina Goldenberg, CNM to perform a PELVIC EXAMINATION. I understand a pelvic exam may be performed as part of my routine or wellness checkup to monitor for possible signs of ovarian cysts, sexually transmitted infections, uterine fibroids or early-stage cancer and are routinely done during pregnancy checkups. Pelvic exams are also performed to investigate symptoms such as abnormal bleeding, unusual vaginal discharge, or pain.

I further understand the pelvic exam includes an external and internal assessment of my genitourinary system including the vulva, vagina, uterus, ovaries, and fallopian tubes; the bladder and rectum. This involves visual examination of the external genitalia and an internal visual exam of the vaginal walls and cervix using a metal speculum (device to open the vaginal canal). A small sample of the cells of the cervix may be taken for a Pap test. To complete the exam, bimanual palpation or touching of the size and shape of the pelvic organs is conducted by inserting two fingers into the vagina and pressing with the other hand on the abdomen followed with a rectal exam (over 40 years old or if there is an issue). While there may be some minor discomfort, a pelvic exam should not be painful.

By signing the document below, the patient or responsible party listed above consent to a **medically indicated examination including but not limited to a pelvic examination.** This consent will remain on file and will not expire.

Patient Signature: _____ **Date:** _____