



Patient Identification Label

### CANCER HISTORY ASSESSMENT

How many sisters in each family:

\_\_\_\_\_ You  
\_\_\_\_\_ Your Mother  
\_\_\_\_\_ Your Father

How many brothers in each family:

\_\_\_\_\_ You  
\_\_\_\_\_ Your Mother  
\_\_\_\_\_ Your Father

Fill in this chart with your family history of any cancer.

Relative	First Name	Cancer Type	Age at Diagnosis	Comments
You				
Daughter				
Daughter				
Son				
Son				
Sister				
Sister				
Brother				
Brother				
Father				
Mother				
Aunt (Father's Side)				
Aunt (Father's Side)				
Uncle (Father's Side)				
Uncle (Father's Side)				
Aunt (Mother's Side)				
Aunt (Mother's Side)				
Uncle (Mother's Side)				
Uncle (Mother's Side)				
Grandfather (Father's Side)				
Grandmother (Father's Side)				
Grandfather (Mother's Side)				
Grandmother (Mother's Side)				
1st Cousin (Father's Side)				
1st Cousin (Father's Side)				
1st Cousin (Mother's Side)				
1st Cousin (Mother's Side)				
(Others)				

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

DO NOT WRITE BELOW THIS LINE

