

THIS IS NOT A TEST REQUEST FORM. Please complete and submit with the test request form or electronic packing list.

HEREDITARY CANCER TESTING PATIENT HISTORY FORM

Patient Name: _____ **Date of Birth:** _____
Sex Assigned at Birth: Female Male Intersex **Gender Identity (optional):** Female Male _____
Ordering Provider: _____ **Provider's Phone:** _____
Practice Specialty: _____ **Provider's Fax:** _____
Genetic Counselor: _____ **Counselor's Phone:** _____

Patient's Ethnicity/Ancestry (check all that apply)

African American/Black Asian Hispanic White Other: _____

List countries of origin (if known): _____

Has the patient been diagnosed with a cancer or tumor? No Yes (Check all that apply and indicate age of diagnosis.)

- | | |
|---|--|
| <input type="checkbox"/> Adrenal (age: _____)
<input type="checkbox"/> Brain (type/age: _____)
<input type="checkbox"/> Breast (age: _____)
<input type="checkbox"/> bilateral <input type="checkbox"/> unilateral
<input type="checkbox"/> ER-/PR-/HER2-
"triple negative" pathology
<input type="checkbox"/> Colorectal (age: _____)
<input type="checkbox"/> Endometrial (age: _____)
<input type="checkbox"/> Gastric (age: _____)
<input type="checkbox"/> Leukemia (age: _____)
<input type="checkbox"/> Medullary thyroid (age: _____)
<input type="checkbox"/> Melanoma (age: _____) | <input type="checkbox"/> Nonmedullary thyroid (type/age: _____)
<input type="checkbox"/> Ovarian (age: _____)
<input type="checkbox"/> bilateral <input type="checkbox"/> unilateral
<input type="checkbox"/> Pancreatic (age: _____)
<input type="checkbox"/> Parathyroid (age: _____)
<input type="checkbox"/> Pheochromocytoma (age: _____)
<input type="checkbox"/> Pituitary (age: _____)
<input type="checkbox"/> Polyposis (#/type: _____)
<input type="checkbox"/> Prostate (age: _____)
<input type="checkbox"/> Renal (age: _____)
<input type="checkbox"/> Skin (age: _____)
<input type="checkbox"/> Other: _____ |
|---|--|

Does the patient have additional clinical findings of a hereditary cancer syndrome? No Yes Unknown
 If yes, describe: _____

Does this patient have a genetic variant(s) previously identified in tumor/bone marrow? No Yes Unknown
 If yes, attach result(s) or describe: _____

Has the patient had an allogeneic bone marrow or umbilical cord blood transplant No Yes Unknown

Has the patient undergone previous DNA testing for hereditary cancer? No Yes Unknown
 If yes, describe the genes, method, and results: _____

Is there any relevant family history of cancers or tumors? No Yes Unknown
 If yes, attach a pedigree or specify the relative's relationship to the patient. List their symptoms and age of onset:

Has DNA testing been performed for the family member(s)? No Yes Unknown
 If yes, attach a copy of the relative's DNA laboratory result (REQUIRED for familial mutation testing).

For questions, contact an ARUP genetic counselor at 800-242-2787 ext. 2141.

