Your name: ________________________  Daytime Phone Number: ________________________

**FAMILY HEALTH HISTORY QUESTIONNAIRE**

Have you or any of your family members had breast cancer before age 50?  
[ ] YES  [ ] NO

Have you or any of your family members had ovarian cancer?  
[ ] YES  [ ] NO

Has any man developed male breast cancer?  
[ ] YES  [ ] NO

Have you or any of your family members had colon or rectal cancer before age 50?  
[ ] YES  [ ] NO

Have you or any of your family members had uterine cancer before age 50?  
[ ] YES  [ ] NO

Have you or any of your family members had 10 or more colon polyps?  
[ ] YES  [ ] NO

Have two or more members of your family had any other type of cancer?  
[ ] YES  [ ] NO

Do you have any questions about your family’s health history or genetics?  
____________________________________________________________________________________
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