VICTORY PHYSICIANS

Cancer Family History

Please complete the following questionnaire regarding these five types of cancer.

Name: _____ Date of Birth: _____

FAMILY HISTORY OF CANCER			
Colon Cancer	Y ☐ N ☐	Mother	Date of First Diagnosis
	Y ☐ N ☐	Father	Date of First Diagnosis
	Y ☐ N ☐	Sisters	Date of First Diagnosis
	Y ☐ N ☐	Brothers	Date of First Diagnosis
	Y ☐ N ☐	Others	Date of First Diagnosis
Breast Cancer	Y ☐ N ☐	Mother	Date of First Diagnosis
	Y ☐ N ☐	Father	Date of First Diagnosis
	Y ☐ N ☐	Sisters	Date of First Diagnosis
	Y ☐ N ☐	Brothers	Date of First Diagnosis
	Y ☐ N ☐	Others	Date of First Diagnosis
Prostate Cancer	Y ☐ N ☐	Mother	Date of First Diagnosis
	Y ☐ N ☐	Father	Date of First Diagnosis
	Y ☐ N ☐	Sisters	Date of First Diagnosis
	Y ☐ N ☐	Brothers	Date of First Diagnosis
	Y ☐ N ☐	Others	Date of First Diagnosis
Cervical Cancer	Y ☐ N ☐	Mother	Date of First Diagnosis
	Y ☐ N ☐	Father	Date of First Diagnosis
	Y ☐ N ☐	Sisters	Date of First Diagnosis
	Y ☐ N ☐	Brothers	Date of First Diagnosis
	Y ☐ N ☐	Others	Date of First Diagnosis
Endometrial Cancer	Y ☐ N ☐	Mother	Date of First Diagnosis
	Y ☐ N ☐	Father	Date of First Diagnosis
	Y ☐ N ☐	Sisters	Date of First Diagnosis
	Y ☐ N ☐	Brothers	Date of First Diagnosis
	Y ☐ N ☐	Others	Date of First Diagnosis

Patient Signature _____ Date _____

Reviewed by Physician _____ Date _____