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PATIENT NAME	
DATE OF BIRTH	**TODAY'S DATE**

Hereditary Cancer Questionnaire

(to be completed by patients)

Instructions: This screening tool helps your healthcare provider assess whether you may benefit from hereditary cancer genetic testing by identifying risk factors such as family patterns of cancer, early-onset cancers, rare cancers, or multiple cancers in one person/side of the family.

1. Have YOU previously had genetic testing for hereditary cancer? ☐ Yes ☐ No

If yes, what is the approx. year you were tested?_____ **Result:** ☐ Positive ☐ Negative ☐ Unknown

Instructions: **Please check YES** or **NO** to any statement below as it applies to **YOU** and/or **YOUR 1st, 2nd or 3rd DEGREE RELATIVES.** Next to each statement, please list the applicable **RELATIVE(S), CANCER TYPE(S),** and **AGE AT DIAGNOSIS.**

- **1st Degree Relatives** = Mother / Father / Sister / Brother / Children
- **2nd Degree Relatives** = Aunt / Uncle / Grandparent / Niece / Nephew
- **3rd Degree Relatives** = First Cousins / Great Grandparents

2. YES	NO	CANCER HISTORY	You, brothers/sisters, children	MOTHER'S SIDE (mother, aunt/ uncle, grandparent)	FATHER'S SIDE (father, aunt uncle, grandparent)
☑	☐	**EXAMPLE:** Three family members with **COLON, UTERINE, STOMACH,** or **SMALL INTESTINE** cancer *on the same side* of your family	Me – Uterine (57)	Grandmother – Uterine (61)	Uncle – Colon (66)
☐	☐	**BREAST** cancer at age 50 or younger, *or* three **BREAST** cancers at any age *on the same side* of your family			
☐	☐	Two different cancers *in the same person* (e.g. **BREAST** *and* **OVARIAN, COLON** *and* **UTERINE**)			
☐	☐	**BREAST** or **PROSTATE** cancer at any age *and* Ashkenazi Jewish ancestry			
☐	☐	Three or more **BREAST** and/or **PROSTATE** cancers at any age *on the same side* of your family			
☐	☐	**COLORECTAL, STOMACH, UTERINE, OVARIAN, PANCREATIC, HIGH-GRADE** AND/OR **METASTATIC PROSTATE, MALE BREAST, TRIPLE NEGATIVE BREAST** cancer at any age.			
☐	☐	Family history of **COLORECTAL UTERINE, STOMACH,** or **SMALL INTESTINE** cancer under age 50			
☐	☐	Three family members with **COLON, UTERINE, STOMACH,** or **SMALL INTESTINE** cancer *on the same side* of your family			
☐	☐	Ten or more **COLORECTAL** polyps (adenomas)			
☐	☐	*Personal* history of a bone marrow or stem cell transplant from a donor**			
☐	☐	If anyone in your family has had genetic testing for hereditary cancer and tested positive, list them here.			
☐	☐	If you have a family history of any **OTHER** cancers, list them here.			

*This is a suggested list of genetic testing criteria and is not comprehensive. There are other situations where genetic testing may be appropriate.
**If yes, then the following specimen types should not be used for genetic testing: blood, saliva, buccal swab. An alternative specimen is required.

If you checked "YES" for any of the questions above, you may benefit from genetic testing. To learn more, return this form to your healthcare provider and scan the QR code on the reverse side for educational resources.

FOR OFFICE USE ONLY:

If the patient answered "Yes" to any of the above questions, they may be eligible for hereditary cancer testing.

Offered the patient hereditary cancer testing: ☐ Yes ☐ No

If YES, did the patient agree to move forward with the testing? ☐ Yes ☐ No (If no, reason:_____)

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Hereditary Cancer Testing with Ambry Genetics



Better understand your risks. Make proactive plans for the future.

Scan here to learn more about hereditary cancer and genetic testing:

Frequently Asked Questions
Short Educational Videos
Patient Guides (English and Spanish)

On The Other Side

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MKT-ONCO-FLYR-20075-EN v16 10.19.26