Riverside MEDICAL GROUP
Your family's complete medical home.

Personal & Family History

Name: _____ Today's Date:____/____/____

Family history is the MOST important insight in how we can better manage YOU. Personalized care begins with knowing your risks. Please complete this thoroughly so you can get the best care possible from our medical staff.

Please Describe Any Cancer(s) You or Your Family Have Had Below

The Following Relatives Should Be Considered: You, Mother, Father, Brother, Sister, Children, Paternal Aunt/Uncle, Maternal Aunt/Uncle, First Cousins, Nieces/Nephews, Maternal and Paternal Grandparents

History Description	Circle	Relative(s)	Paternal/ Maternal	Age(s) of Diagnosis
Colon Cancer before the age of **50 or two diagnosis of colon cancer** on the same side of the family	**YES**			
Uterine/Endometrial cancer before the age of **50**	**YES**			
One of the following cancers: Ovarian, pancreatic, or gastric cancer(s) in your family?	**YES**			
One of the following cancers: small bowel, liver, kidney, or brain cancer(s) in your family?	**YES**			
Breast Cancer diagnosed at or before the age of **50**	**YES**			
Ovarian Cancer diagnosed at **any age**	**YES**			
Male Breast Cancer diagnosed at **any age**	**YES**			
Three or more breast cancers on the same side of the family regardless of age	**YES**			
A relative diagnosed with breast cancer **twice**	**YES**			
Ashkenazi Jewish ancestry w/ Breast, Ovarian, or Pancreatic cancer in same person or on the same-side of the family	**YES**			
Any diagnosis of pancreatic cancer with breast cancer in the same family member?	**YES**			
Have you or any of your family members been tested for the BRCA gene? If no, why not?	**YES**			
Please list any other cancers, what relative, and side of the family:				

OFFICE USE ONLY: Genetic Testing: Accepted ☐ Denied ☐Signature:_____
If declined state reason: _____