color

Patient full name, DOB:

Health History (Male) Form

Hereditary Cancer Test

Fill in your personal and family health history to the best of your knowledge, and estimate when you need to. If there isn't enough space to adequately answer a question, feel free to write it on the side.

GENERAL

1. What is your ancestry? (check all that apply)

- ☐ African
- ☐ Asian
  - ☐ Chinese
  - ☐ Japanese
  - ☐ Filipino
  - ☐ Hawaiian
  - ☐ Other Pacific Islander
  - ☐ Other Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Native American
- ☐ Unknown
- ☐ Other: _____

2. Are you of Ashkenazi Jewish descent? Ashkenazi Jewish individuals are individuals whose ancestors are Jews from Eastern European countries.

- ◯ No
- ◯ Yes
- ◯ I'm not sure

3. Why are you having genetic testing done?

- ☐ Learn if my family history of cancer is hereditary
- ☐ Learn if my personal history of cancer is hereditary
- ☐ Learn if I carry a mutation known to run in my family
- ☐ I'm curious to know more about my genetics

CANCER HISTORY

4. If you have ever had cancer, please provide details.

- ☐ Male breast cancer, diagnosed at _____ years old.
  - ☐ Breast cancer affected both breasts.

  What type of breast cancer did you have?
    - ☐ Ductal Carcinoma In Situ (DCIS)
    - ☐ Ductal Carcinoma
    - ☐ Lobular Carcinoma
- ☐ Colon (colorectal) cancer, diagnosed at _____ years old.
- ☐ Stomach (gastric) cancer, diagnosed at _____ years old.

  What type of stomach (gastric) cancer did you have?
    - ☐ Adenocarcinoma
    - ☐ Diffuse gastric cancer

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CANCER HISTORY
(Continued)

4. If you have ever had cancer, please provide details. (Continued)

- ☐ Melanoma, diagnosed at _____ years old.
- ☐ Prostate cancer, diagnosed at _____ years old.
- ☐ Hematological malignancy (for example, Leukemia, Lymphoma, or Multiple myeloma)
  - ◯ I am in active treatment
  - ◯ I have been in remission for _____ years.
- ☐ _____ cancer, diagnosed at _____ years old.
- ☐ _____ cancer, diagnosed at _____ years old.

5. Have you ever had colon polyps identified on colonoscopy or sigmoidoscopy?

- ◯ No
- ◯ Yes, approximately _____ (number) of polyps have been found in my lifetime.
- ◯ I'm not sure

6. Have you had a genetic test for hereditary cancer risk?

- ◯ No
- ◯ Yes, the test was performed by the following lab: (Please provide reports of previous testing if available.)
  - ◯ Ambry Genetics
  - ◯ Color Genomics
  - ◯ Counsyl
  - ◯ GeneDx
  - ◯ Invitae
  - ◯ LabCorp
  - ◯ Myriad Genetics
  - ◯ _____

  Please list any pathogenic or likely pathogenic mutations that were identified:

  - ☐ In the BRCA1 gene. Mutation name, if available: _____
  - ☐ In the BRCA2 gene. Mutation name, if available: _____
  - ☐ Other gene (also list mutation name, if available): _____

7. Have you had a bone marrow transplant?

- ◯ No
- ◯ Yes

  Was the transplanted bone marrow your own?

  - ◯ No
  - ◯ Yes

8. Have you had a blood transfusion in the week before providing your saliva sample to Color?

- ◯ No
- ◯ Yes

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FAMILY HEALTH HISTORY

9. Are you adopted or do you have no health information about one, or both sides of your biological family members?

- ◯ No
- ◯ Yes
  - ☐ Mother
  - ☐ Mother's family
  - ☐ Father
  - ☐ Father's family
  - ☐ Siblings

You can skip questions related to the family members you are missing information for. If you are just lacking confidence in some of your answers though, please make your best guess.

10. Please provide ages (current or at death) and cancer history for your biological family members.

Females relatives: Provide cancer history for breast, ovarian, fallopian tube, primary peritoneal, and other cancers.
Male relatives: Provide cancer history for male breast and other cancers.

	Age Currently or at death	Deceased?	Cancer history Type and age at diagnosis
Mother			
Father			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Please only list biological parents and grandparents.

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FAMILY HEALTH HISTORY
(Continued)

10. Please provide ages (current or at death) and cancer history for your biological family members.

Females relatives: Provide cancer history for breast, ovarian, fallopian tube, primary peritoneal, and other cancers.
Male relatives: Provide cancer history for male breast and other cancers.

	Age Currently or at death	Deceased?	Half sibling Which parent?	Cancer history Type and age at diagnosis
Sister 1				
Sister 2				
Sister 3				
Brother 1				
Brother 2				
Brother 3				

Please list biological full and half brothers and sisters.

	Age Currently or at death	Deceased?	Cancer history Type and age at diagnosis
Mother's sister 1			
Mother's sister 2			
Mother's sister 3			
Mother's brother 1			
Mother's brother 2			
Mother's brother 3			

Please only list your mother's full biological brothers and sisters.

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FAMILY HEALTH HISTORY
(Continued)

10. Please provide ages (current or at death) and cancer history for your biological family members.

Females relatives: Provide cancer history for breast, ovarian, fallopian tube, primary peritoneal, and other cancers.
Male relatives: Provide cander history for male breast and other cancers.

	Age Currently or at death	Deceased?	Cancer history Type and age at diagnosis
Father's sister 1			
Father's sister 2			
Father's sister 3			
Father's brother 1			
Father's brother 2			
Father's brother 3			

Please only list your father's full biological brothers and sisters.

	Age Currently or at death	Deceased?	Cancer history Type and age at diagnosis
Daughter 1			
Daughter 2			
Daughter 3			
Son 1			
Son 2			
Son 3			

Please only list your biological children.

11. Have any of your female or male relatives had a genetic test for hereditary cancer risk?

◯ No

◯ Yes (Please provide reports of previous testing if available.)

For any pathogenic or likely pathogenic mutations found: list the relative, gene, and mutation name (if available).

12. Is there anything else related to cancer history or known genetic mutations that you would like to share?

Thank you!

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Fill in your personal and family health history to the best of your knowledge, and estimate when you need to. If there isn't enough space to adequately answer a question, feel free to write it on the side.

PERSONAL HISTORY

1. Have you ever been told that you have high cholesterol?

- ◯ No
- ◯ Yes

  Please indicate your most recent LDL-C level. If you currently take medication to treat your high cholesterol, enter your LDL-C level prior to starting treatment.

  - ◯ Less than 154
  - ◯ 155-189
  - ◯ 190-249
  - ◯ 250-329
  - ◯ 330 or higher
  - ◯ I'm not sure
- ◯ I'm not sure

2. Have you ever had a heart attack or stroke?

- ◯ No
- ◯ Yes
  - ☐ Heart attack when I was _____ years old.
  - ☐ Stroke when I was _____ years old.

3. Have you ever had heart failure?

- ◯ No
- ◯ Yes, when I was _____ years old.

4. Have you ever had heart or vascular surgery, such as a bypass, stent, or angioplasty?

- ◯ No
- ◯ Yes

  Type of surgery (check all that apply):
  - ☐ Bypass surgery when I was _____ years old.
  - ☐ Stent placement when I was _____ years old.
  - ☐ Angioplasty when I was _____ years old.

5. Have you ever been told you have cholesterol deposits on your eyelids (xanthelasma) or in your tendons (xanthoma)?

- ◯ No
- ◯ Yes
  - ☐ Xanthelasma
  - ☐ Xanthoma

6. Have you ever been told you have a white ring around your iris, the colored part of your eye (corneal arcus)?

- ◯ No
- ◯ Yes, when I was _____ years old.

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PERSONAL HISTORY
(Continued)

7. Have you ever been told you have a diagnosis of Familial Hypercholesterolemia (FH)?

- ◯ No
- ◯ Yes

8. Have you ever had a genetic test for FH?

- ◯ No
- ◯ Yes

Who performed the genetic test? Select a lab:

- ☐ Ambry Genetics
- ☐ ApolloGen
- ☐ Correlagen Diagnostics
- ☐ GeneDx
- ☐ Integrated Genetics
- ☐ Invitae
- ☐ Mayo Clinic
- ☐ Prevention Genetics
- ☐ Unknown
- ☐ Other: _____

Was a mutation identified?

- ◯ No
- ◯ Yes

Select gene:

- ☐ *APOB*
- ☐ *LDLR*
- ☐ *LDLRAP1*
- ☐ *PCSK9*
- ☐ Other

If gene selected, mutation name if available: _____

- ◯ I'm not sure

9. Have you had a bone marrow transplant?

- ◯ No
- ◯ Yes

Was the transplanted bone marrow your own?

- ◯ No
- ◯ Yes

10. Have you had a blood transfusion in the week before providing your saliva sample to Color?

- ◯ No
- ◯ Yes

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FAMILY HEALTH HISTORY

11. Please provide ages (current or at death) and family history for your biological family members.

	Age Currently or at death	High cholesterol	Heart attack or stroke Include age when it occured	Heart or vascular surgery Include surgery type (bypass, stent, angioplasty etc.)	Died suddenly from cardiac or unexplained causes Include age at death	Cholesterol deposits on the eyelids (xanthelasma) or in the tendons (xanthoma)	White ring around the iris, the colored part of eye (corneal arcus)
Mother							
Father							
Maternal grandmother							
Maternal grandfather							
Paternal grandmother							
Paternal grandfather							

Please only list biological parents and grandparents.

	Age Currently or at death	High cholesterol	Heart attack or stroke Include age when it occured	Heart or vascular surgery Include surgery type (bypass, stent, angioplasty etc.)	Died suddenly from cardiac or unexplained causes Include age at death	Cholesterol deposits on the eyelids (xanthelasma) or in the tendons (xanthoma)	White ring around the iris, the colored part of eye (corneal arcus)
Sister 1							
Sister 2							
Sister 3							
Brother 1							
Brother 2							
Brother 3							

Please list biological full and half brothers and sisters.

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FAMILY HEALTH HISTORY *(Continued)*

11. Please provide ages (current or at death) and family history for your biological family members.

	Age Currently or at death	High cholesterol	Heart attack or stroke Include age when it occured	Heart or vascular surgery Include surgery type (bypass, stent, angioplasty etc.)	Died suddenly from cardiac or unexplained causes Include age at death	Cholesterol deposits on the eyelids (xanthelasma) or in the tendons (xanthoma)	White ring around the iris, the colored part of eye (corneal arcus)
Mother's sister 1							
Mother's sister 2							
Mother's sister 3							
Mother's brother 1							
Mother's brother 2							
Mother's brother 3							

Please only list your mother's full biological brothers and sisters.

	Age Currently or at death	High cholesterol	Heart attack or stroke Include age when it occured	Heart or vascular surgery Include surgery type (bypass, stent, angioplasty etc.)	Died suddenly from cardiac or unexplained causes Include age at death	Cholesterol deposits on the eyelids (xanthelasma) or in the tendons (xanthoma)	White ring around the iris, the colored part of eye (corneal arcus)
Father's sister 1							
Father's sister 2							
Father's sister 3							
Father's brother 1							
Father's brother 2							
Father's brother 3							

Please only list your father's full biological brothers and sisters.

FAMILY HEALTH HISTORY *(Continued)*

11. Please provide ages (current or at death) and family history for your biological family members.

	Age Currently or at death	High cholesterol	Heart attack or stroke Include age when it occured	Heart or vascular surgery Include surgery type (bypass, stent, angioplasty etc.)	Died suddenly from cardiac or unexplained causes Include age at death	Cholesterol deposits on the eyelids (xanthelasma) or in the tendons (xanthoma)	White ring around the iris, the colored part of eye (corneal arcus)
Daughter 1							
Daughter 2							
Daughter 3							
Son 1							
Son 2							
Son 3							

Please only list your biological children.

FAMILY HEALTH HISTORY *(Continued)*

12. Has anyone had a genetic test for Familial Hypercholesterolemia (FH)?

- ◯ No
- ◯ Yes (Please provide reports of previous testing if available.)

For any mutations found: list the relative, gene, and mutation name (if available).

13. Is there anything else related to your personal or family history that you would like to share?

Thank you!

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