

Track your history & know your options.

Use this chart to keep track of breast, ovarian, and related cancers in your family and indicate if anyone is a known BRCA gene mutation carrier. If you have a history of cancer in your family, get in touch with us to schedule a free consultation with a genetic counselor or to learn more about the resources available to you.

Your Generation	Your Mother's Side	Your Father's Side
<p>YOU</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>MOTHER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>FATHER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>
<p>BROTHER/SISTER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>GRANDMOTHER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>GRANDMOTHER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>
<p>BROTHER/SISTER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>GRANDFATHER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>GRANDFATHER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>
<p>BROTHER/SISTER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>AUNT/UNCLE</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>AUNT/UNCLE</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>
<p>BROTHER/SISTER</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>AUNT/UNCLE</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>	<p>AUNT/UNCLE</p> <p>NAME: _____</p> <p><input type="checkbox"/> HAD BREAST OR OVARIAN CANCER</p> <p><input type="checkbox"/> HAD OTHER CANCER: _____</p> <p>AGE AT DIAGNOSIS: _____</p> <p>IF TESTED: <input type="checkbox"/> CARRIER <input type="checkbox"/> NON-CARRIER</p>

For more information visit us at www.facebook.com/sharsheret.org or call 866.474.2774.