

BREAST CANCER RISK ASSESSMENT

PATIENT NAME: _____ **DOB:** _____ **HEIGHT:** _____ **WEIGHT:** _____

Do you have any **BREAST** complaints? YES / NO

(Example: Lump / Nipple Discharge / Pain / Skin Changes like dimpling, rash, etc. / Tenderness (not related to menstrual cycle))

Have you had a **CLINICAL BREAST EXAM** by your physician? YES / NO If so, when? (mo/yr)

Are you: Pre-menopausal / Peri-menopausal / Post-menopausal

Age of Menopause (if applicable): _____ Age of First Menstruation: _____

Age of Delivery of First Child (if applicable): _____

Hormone Replacement Therapy: (Please circle all that apply)

Current Use / Less than 5 Years Ago / More than 5 Years Ago / Never / If Used: Total Years Used: _____

Medication: Estrogen / Combined Estrogen-Progesterone / Other: _____

Prior or Current Breast Cancer Medications: (i.e. Tamoxifen, etc.) YES / NO

Are you currently pregnant? YES / NO

Have you had **OVARIAN or BREAST CANCER**? _____ YES / NO Age of Diagnosis: _____

Are you of Ashkenazi Jewish Ancestry (Eastern European)? YES / NO

Has anyone in your family had '**Genetic Testing**'? YES / NO

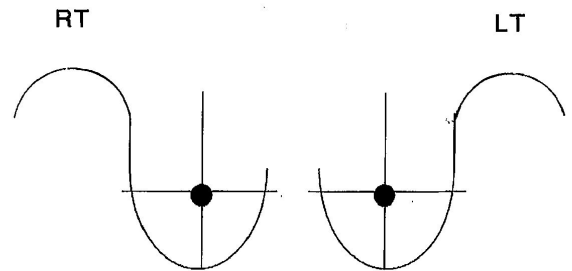
Please indicate result (e.g. BRCA, Panel, etc.) _____

Do you have a history of Hodgkin's Diseases treated with chest radiation therapy? YES / NO

Have you had any of the following procedures? YES / NO

If yes, which procedure and which breast?

Have you had any changes in your breasts? YES / NO	Have you had any changes in your breasts? YES / NO	Have you had any changes in your breasts? YES / NO
Patient: _____	Patient: _____	Patient: _____
Tech Initial: _____	Tech Initial: _____	Tech Initial: _____
Date: _____	Date: _____	Date: _____
Lifetime Risk: _____ (If Applicable)	Lifetime Risk: _____ (If Applicable)	Lifetime Risk: _____ (If Applicable)



Procedure	Right Breast	Left Breast	Date
Chemotherapy			
Mastectomy			
Lumpectomy			
Radiation			
Implants			
Reduction			
Biopsy			

FOR OFFICE USE ONLY
Heredity Cancer (HC) Red Flags (To be completed by your healthcare provider – check all that apply)

Ashkenazi Jewish ancestry with an HBOC-associated cancer‡§

‡In the same individual or on the same side of the family
 §HBOC-associated cancers include breast (including DCIS), ovarian, pancreatic

Personal **and/or** family history of any one of the following:

<input type="checkbox"/>	Young Any 1 of the following at age 50 or younger :	<input type="radio"/> Breast cancer <input type="radio"/> Colorectal cancer <input type="radio"/> Endometrial cancer
<input type="checkbox"/>	Rare Any 1 of these rare cancers at any age :	<input type="radio"/> Ovarian cancer <input type="radio"/> Male breast cancer
<input type="checkbox"/>	Multiple A combination of 3 or more cancers on the same side of the family:	<p>HBOC <u>3 or more</u>: breast / ovarian / prostate / pancreatic cancer</p> <hr/> <p>LYNCH <u>3 or more</u>: colorectal / endometrial/ovarian/gastric/pancreatic/other (i.e., ureter/renal pelvis, biliary tract, small bowel, brain, sebaceous adenomas)</p>

Patient meets HC Red Flags	
YES	NO
10 year risk	____%
Lifetime risk	____%

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

Patient appropriate for hereditary cancer genetic testing? YES NO

ACCEPTED DECLINED (Reason)

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Follow-up appointment scheduled: YES NO

Date of Appointment: