See the difference
GREAT LAKES MEDICAL IMAGING

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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

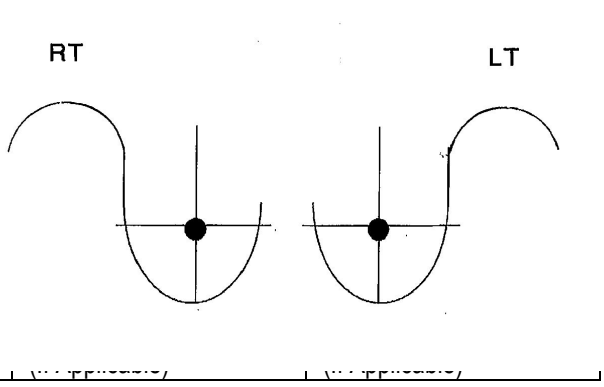
Please indicate result (e.g. BRCA, Panel, etc.) _____

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 breas 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			

Prior Biopsy Results (if applicable): Benign / Hyperplasia / Atypical Hyperplasia / LCIS / DCIS / Invasive Cancer / Other:

		If applicable, estimate age of diagnosis (e.g. 30s, 40s, 50s, 60s, etc.) in boxes below							
	Current age or age of death	**Breast**	**Prostate**	**Pancreatic**	**Ovarian**	**Colon**	**Endometrial (Uterine)**	**Gastric**	**Other: brain, ureter-pelvis, biliary tract, small bowel, sebaceous adenoma**
Mother									
Father									
Son / Daughter									
Son / Daughter									
Sister 1									
Sister 2									
Brother 1									
Brother 2									
Niece / Nephew									
Grandmother									
Grandfather									
Aunt 1									
Aunt 2									
Aunt 3									
Uncle 1									
Uncle 2									
Uncle 3									
Great Grandmother									
Great Grandfather									
Cousin (s)									
Grandmother									
Grandfather									
Aunt 1									
Aunt 2									
Uncle 1									
Uncle 2									
Great Grandmother									
Great Grandfather									
Cousin (s)									

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

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)

Follow-up appointment scheduled: YES NO **Date of Appointment:**