Every Woman's Life

BREAST AND CERVICAL CANCER RISK ASSESSMENT FORM

PATIENT INFORMATION

Name: _____

_____

Breast Questions

1. Have you ever had breast cancer? ☐ Yes ☐ No
   Age at diagnosis: _____ ☐ Right ☐ Left ☐ Bilateral

2. Do you have a close family history of breast cancer, ovarian cancer, or other hereditary breast and ovarian syndrome-associated cancer? ☐ Yes ☐ No

3. Family history of cancer? ☐ Yes ☐ No

4. If yes, please circle:

   Paternal/Maternal _____, cancer site_____,
   (relationship)

   age at diagnosis (if known) _____.

   Paternal/Maternal _____, cancer site_____,
   (relationship)

   age at diagnosis (if known) _____.

   Paternal/Maternal _____, cancer site_____,
   (relationship)

   age at diagnosis (if known) _____.

   Paternal/Maternal _____, cancer site_____,
   (relationship)

   age at diagnosis (if known) _____.

5. Do you have a 1st degree relative (mother, sister) who is a breast cancer gene carrier (BRCA)?
   ☐ Yes ☐ No

6. Do you have a known genetic mutation such as BRCA1 or BRCA2? ☐ Yes ☐ No

7. Have you had prior breast biopsy? ☐ No ☐ Atypical Ductal Hyperplasia ☐ Hyperplasia (not atypia) ☐ Lobular Carcinoma in-situ?

8. Have you had prior exposure to high-dose therapeutic chest irradiation when you were between the ages of 10 and 30? ☐ Yes ☐ No

9. Are you having any **NEW** problems of the following:

Nipple Discharge (Clear/Bloody)	☐ Yes	☐ No	☐ Right	☐ Left
Nipple Inversion (goes inward)	☐ Yes	☐ No	☐ Right	☐ Left
Breast Lump or Mass	☐ Yes	☐ No	☐ Right	☐ Left

10. Have you had a clinical breast exam in the last 3 months? This is an exam performed by a doctor to check for lumps or other breast changes.
☐ Yes, where done_____
☐ No.

11. Would you like to have a breast exam done? ☐ Yes ☐ No

Cervical Questions

1. Age of first menstrual period? _____
2. Date of last menstrual period? _____
3. Have you given birth to one or more children? ☐ Yes ☐ No
4. Number of pregnancies? _____
5. Number of living children? _____
6. Age when delivered your first live birth? _____
7. Have you had an abortion? ☐ Yes ☐ No
8. Have you had any miscarriages? ☐ Yes ☐ No
9. Have you gone through menopause? ☐ Don't Know ☐ Yes ☐ No ☐ In Menopause Now
10. At what age was menopause? _____
11. Are you taking or have you taken any hormone replacement therapy? ☐ Never
    ☐ Stopped Use 5 or More Years Ago ☐ Stopped Use Less than 5 Years Ago ☐ Current User
12. Have you been previously treated for Cervical Intraepithelial Neoplasia (CIN) or cervical cancer?
    ☐ Yes ☐ No
13. Do you have a personal history of HIV infection? ☐ Yes ☐ No
14. Are you immunocompromised (received solid organ transplants)? ☐ Yes ☐ No
15. Did your mother take diethylstilbesterol (DES) when pregnant with you? This was a type of estrogen given to pregnant women between 1940 and 1971 to prevent miscarriages. ☐ Yes ☐ No ☐ Don't Know
16. Have you had hysterectomy? ☐ Yes ☐ No ☐ Partial ☐ Complete
17. Are you having any **NEW** problems of the following:

    Vaginal Discharge ☐ Yes ☐ No

    Abnormal/Unusual Vaginal Bleeding ☐ Yes ☐ No