# Center for Breast Care

| Name: | | |
|---|---|---|
| Age: | Height: | Weight: |

## Breast Cancer Risk Assessment Questionnaire

| | | |
|---|---|---|
| How old were you when you started having periods? | | When was your last period? |
| Are your menstrual periods regular? | Yes / No | |
| Have you undergone menopause? | Yes / No | When? |
| Did you have a hysterectomy? | Yes / No | |
| Have you ever taken hormones for menopause symptoms? | Yes / No | How may years? |

## Reproductive History

| | | |
|---|---|---|
| Have you ever used oral contraceptives? | Yes / No | How long? |
| Are you presently taking oral contraceptives? | Yes / No | |
| Have you ever been pregnant? | Yes / No | How many times? |

How many?: Delivered _____ Miscarriages _____ Terminations _____

How old were you when your first child was born? _____

| | | |
|---|---|---|
| Did you breast feed your child(ren)? | Yes / No | How long? |
| Have you ever taken medication for infertility? | Yes / No | How long? |
| Have you had a recent pap smear? | Yes / No | When? |

## Self-Breast Exam

| | | | |
|---|---|---|---|
| Have you ever had a breast lump that you could feel? | Yes / No | Breast cyst? | Yes / No |
| Have you ever had a biopsy? | Yes / No | Breast surgery? | Yes / No |
| Do you do breast self-exams? | Yes / No | | |
| Do you have pain in either breast? | Yes / No | | |
| Have you had bleeding or discharge from either nipple? | Yes / No | | |
| Have you noticed any changes in your breasts | Yes / No | | |

## Family History

| | |
|---|---|
| Ashkenazi Jewish Heritage? | Yes / No |
| Is there a known breast cancer mutation in the family? | Yes / No |

| **Breast Cancer – (Other Cancer type, if known)** | | **Other Diseases** |
|---|---|---|
| **Maternal** | Yes / No | |
| Mother | Yes / No | |
| Grandmother/Grandfather | Yes / No | |
| Aunts/Uncles | Yes / No | |
| Cousins | Yes / No | |
| **Paternal** | | |
| Father | | |
| Grandmother/Grandfather | Yes / No | |
| Aunts/Uncles | Yes / No | |
| Cousins | Yes / No | |
| **Siblings** | | |
| Sisters | Yes / No | |
| Brothers | Yes / No | |
| **Children** | | |
| Daughters | Yes / No | |
| Sons | Yes / No | |

Signature: _____ Date: _____