BROWN SURGICAL ASSOCIATES
BROWN PHYSICIANS, INC.

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		
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: _____