

Name _____

Date _____

Symptoms

- | | | | | | | |
|---|-------------------------------|------------|----|--------------------|---|---|
| 1 | Do you feel a mass/lump? | yes | no | If so, which side? | R | L |
| 2 | Do you have breast pain? | yes | no | If so, which side? | R | L |
| 3 | Do you have nipple discharge? | yes | no | If so, which side? | R | L |
| 4 | When was your last period? | Date _____ | | or Age _____ | | |

Risk Analysis

- | | | | | | |
|---|--|------------------------------|----------|------------------|--|
| 1 | Race | Caucasian | Hispanic | African-American | |
| 2 | Current Age _____ | (valid only if > 35) | | | |
| 3 | Age of first menses _____ | (if < 10, enter 10) | | | |
| 4 | Age of first live birth _____ | (0= none; if < 13, enter 13) | | | |
| 5 | Number of sisters, daughters, or mother with breast cancer _____ | | | | |
| 6 | Number of previous breast biopsies _____ | | | | |
| 7 | (If #6 is positive) Biopsy with atypical hyperplasia | yes | no | unknown | |

Genetic Evaluation

- | | | | | |
|---|---|-----|----|---|
| 1 | Any family members with ovarian cancer? | yes | no | ▶ _____
If yes, who and at what age were they diagnosed? |
| 2 | Any male family members with breast cancer? | yes | no | ▶ _____
If yes, who and at what age were they diagnosed? |
| 3 | Are you of Ashkenazi Jewish descent? | yes | no | |
| 4 | Any female family members with breast cancer? | yes | no | ▶ _____
If yes, who and at what age were they diagnosed? |

Lifestyle/Environmental Factors

- | | | | | |
|---|---|--------------|----|-----------------------------------|
| 1 | Have you ever used hormone replacement therapy? | yes | no | _____ If yes, for how many years? |
| 2 | Have you had radiation therapy? | yes | no | _____ If yes, why? |
| 3 | Do you average more than one drink of alcohol per day? | yes | no | |
| 4 | Do you exercise regularly? | yes | no | |
| 5 | Did you breastfeed your children? | yes | no | |
| 6 | What is your current height and weight? | height _____ | | weight _____ |
| 7 | If you are post-menopausal, have you gained weight? | yes | no | _____ if yes, how many pounds? |
| 8 | Do you have a diet high in fruits and vegetables and low in fat? | yes | no | |
| 9 | Would you be willing to participate in clinical trials/research for breast cancer prevention/treatment? | yes | no | |