BREAST CENTER
of ACADIANA

BREAST CANCER SCREENING: HISTORY AND RISK ASSESSMENT

Name: _____ DOB: _____ Age: _____ Date: _____

Referring Doctor: _____ If you would you like to have your breast imaging report sent to any other doctor(s) please list them here: _____

_____

1. Is this your first mammogram? YES NO If no, when and where was your last mammogram performed? _____

_____

2. Do you have any **new** problems related to your breasts since your last visit? YES NO If yes, please describe: _____

_____

3. Do you have breast implants? YES NO

4. Have you had a breast biopsy for something that was not cancer (benign)? YES NO

If yes, were you told that it was high-risk? YES NO Or that it could turn into cancer? YES NO

5. Have you ever had breast cancer? YES NO More than once? YES NO

6. Have you ever had ovarian cancer? YES NO

7. List family members, by relationship, who have had **breast** cancer and at what age they were diagnosed:

PRIMARY FAMILY (Mother, Father, Sister, Daughter etc.)	YOUR MOTHER'S SIDE (Grandparent, Aunt, Cousin)	YOUR FATHER'S SIDE (Grandparent, Aunt, Cousin)
_____ Age _____	_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____	_____ Age _____

8. List family members, by relationship, who have had **ovarian** cancer and at what age they were diagnosed:

PRIMARY FAMILY (Mother, Sister, Daughter)	YOUR MOTHER'S SIDE (Grandmother, Aunt, Cousin)	YOUR FATHER'S SIDE (Grandmother, Aunt, Cousin)
_____ Age _____	_____ Age _____	_____ Age _____
_____ Age _____	_____ Age _____	_____ Age _____

9. Have you or anyone in your family had a blood test for a breast cancer gene? YES NO If yes, how are they related to you and what were the results? _____

10. Have BOTH of your ovaries been removed? YES NO

11. Are you currently taking female hormones? YES NO If yes, for how long? _____

12. Have you stopped taking female hormones or changed hormone medication since your last mammogram? YES NO

13. Height _____ Weight _____

14. Have you lost weight since your last mammogram? YES NO If yes, how much? _____ pounds

15. Do you have an immune system condition or disease (lupus, rheumatoid arthritis, colitis, psoriasis, or other)? YES NO

16. Do you have any condition or disease which may cause enlarged lymph nodes? YES NO

17. Have you had a vaccination shot in the past 6 months? YES NO If yes, which arm? RIGHT LEFT