MUNSON HEALTHCARE
Smith Family Breast Health Center

11327

RISK ASSESSMENT QUESTIONNAIRE

Participant Name:		Date of Birth:	
I prefer to participate	☐ Yes	☐ No	A*
I participated earlier this year **(Do not answer remaining questions. Please sign and date form)**	☐ Yes	☐ No	B*
I have previously been identified as high risk but **I do not** have a personal history of breast cancer. **(Do not answer remaining questions. Please sign and date form)**	☐ Yes	☐ No	C*
Have you ever been diagnosed with invasive breast cancer or ductal carcinoma in situ (DCIS)?	☐ Yes - **Skip to Family History**		D1
	☐ No		
Have you ever been diagnosed with lobular carcinoma in situ (LCIS)?	☐ Yes - **Skip to Family History**		D2
	☐ No		

***If you are between the ages of 35-85, please answer all of the questions.**
***If you are younger than 35 or older than 85, please skip to Family History below:**

MODIFIED GAIL MODEL

What is your age?	Years
At what age did you start your menstrual period?	Years
What was your age when your first child was born?	Years
How many of your sisters, daughters or mother have had breast cancer?	
Have you ever had a breast biopsy?	☐ Unknown ☐ Yes ☐ No
a. How many biopsies have you had?	Any type
b. Have you had at least one biopsy with atypical hyperplasia (pre-cancerous cells)	☐ Unknown ☐ Yes ☐ No

What is your ethnicity/race? *(please select one)* *includes Middle Eastern, Indian sub-continent, Northern Africa (i.e. Egypt)	☐ White* ☐ African American ☐ Asian or Pacific Islander	☐ American Indian or Alaskan native ☐ Hispanic ☐ Unknown

Family History of Cancer: Consider mother's AND father's side - if you don't know exact information regarding your family history, do the best you can, it is ok to estimate age of diagnosis (i.e., 50's, 60's)

Do you have any blood relatives that have been diagnosed with cancer?

Mother ☐ Yes ☐ No age:_____ type:_____ **Sister(s)** ☐ Yes ☐ No _____ *list age of diagnosis and type*

Father ☐ Yes ☐ No age:_____ type:_____ **Brother(s)** ☐ Yes ☐ No _____ *list age of diagnosis and type*

Daughter(s) ☐ Yes ☐ No _____ *list age of diagnosis and type* **Son(s)** ☐ Yes ☐ No _____ *list age of diagnosis and type*

Do you have any blood relatives on your <u>mother's</u> side with cancer?

Grandmother ☐ Yes ☐ No _____ *list age of diagnosis and type* **Grandfather** ☐ Yes ☐ No _____ *list age of diagnosis and type*

Aunt(s) _____ *list age of diagnosis and type* **Uncles(s)** _____ *list age of diagnosis and type*

Cousin(s) _____ *list age of diagnosis and type*

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Do you have any blood relatives on your Father's side with cancer?

Grandmother ☐ Yes ☐ No _____ *list age of diagnosis and type*

Grandfather ☐ Yes ☐ No _____ *list age of diagnosis and type*

Aunt(s) _____ *list age of diagnosis and type*

Uncles(s) _____ *list age of diagnosis and type*

Cousin(s) _____ *list age of diagnosis and type*

PERSONAL MEDICAL HISTORY	
Have you had **Chest radiation** for Hodgkin's Lymphoma or **Chest radiation** for another cancer before age 30? (This does not include radiation for breast cancer)	☐ Unknown ☐ Yes ☐ No
Have you had genetic testing for BRCA1& BRCA2 genes ?	☐ Unknown ☐ Yes ☐ No
If yes, what are the BRCA 1/2 genetic test results:	☐ Unknown ☐ Negative ☐ Positive
Have you had other genetic tests performed?	☐ Unknown ☐ Yes ☐ No
If yes, what tests and what are the results? (please list)	1._____ 2._____
PERSONAL RISK FACTORS	
Ashkenazi Jewish	☐ Yes ☐ No
History of ovarian cancer?	☐ Yes ☐ No *If yes*, age: _____
History of endometrial/uterine cancer?	☐ Yes ☐ No *If yes*, age: _____
History of other cancer?	☐ Yes ☐ No *If yes*, age: _____ What type? _____

This information will help us to better understand your risk for breast cancer and will help us to determine the most effective way to manage that risk.
You may be contacted by Dana Hoffman, a nurse practitioner in our cancer genetics clinic, or Hilary Tarsney, Coordinator of our high risk clinic, to discuss this information.

Please list your preferred phone # _____, ☐ ***it is okay to leave a detailed message***

***Best time to call*:** _____

Signature:_____ **Date:**_____

High Risk Breast Program Use only

Gail Model Lifetime Risk: %	Tyrer-Cuzick Lifetime Risk: %
☐ NOT HIGH RISK	
Reviewed by:	Date:
☐ Letter sent to patient: Date/Sender:	☐ Letter faxed to HCP Date/Sender:
☐ Appointment Date:	Time:
☐ Genetics paperwork sent to patient	
☐ Patient declined follow-up	

PATIENT ID LABEL

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