BETHESDA HEALTH
WOMEN'S HEALTH CENTER

Address:_____
City:_____ **State:**_____ **Zip:**_____
Phone:_____

Name: _____ **Date of birth:** _____ **Age:**_____

Height:_____ **Weight:**_____ **Age of First Period:**_____ **Age at Birth of 1st Child**____

Have you gone through menopause? YES or NO Age of menopause:___ **or Date of last period:**__

Have you ever used Hormone Replacement Therapy? YES or NO
How long ? _____ **If previous use, when did you quit taking?**_____

Please list physicians you would like to receive today's results:

PCP (Primary Care Physician)_____ **OB/GYN:** _____

Other Physicians: _____

PLEASE answer **ALL** of the following questions. **CIRCLE** the appropriate answers and/or fill in the blanks.

1. ARE YOU PREGNANT NOW? YES NO

2. When was your last mammogram? _____ Where?_____

3. Did you experience discomfort during your last mammogram? 1 Minimal 2 3 Moderate 4 5 Severe

4. Why are you having this breast study? Routine/Yearly YES NO

Do you feel **ANY LUMPS TODAY**?	YES	NO	RT	LT	
Breast Pain or soreness today?	YES	NO	RT	LT	
Any Discharge from Nipple?	YES	NO	RT	LT	Color or Discharge_____ How long_____
Any nipple changes on your breast?	YES	NO	RT	LT	

5. Have you ever had breast cancer? YES NO

When?_____ What age?_____ Which breast(s) Right Left

Type of breast cancer? ❒ DCIS ❒ Invasive Ductal ❒ Invasive Lobular
Other_____

What surgery/treatment(s) did you have? ❒ Lumpectomy ❒ Mastectomy
❒ Radiation ❒ Chemotherapy ❒ Tamoxifen ❒ Evista ❒ Other _____

6. Have you had a breast biopsy or surgery for reasons **OTHER** than for breast cancer? YES NO

Type of surgery: ❒ Biopsy ❒ Implants ❒ Reduction ❒ Breast lift ❒ Other: _____

How many surgeries? Right_____ Left_____

When (year)? Right_____ Left_____

Result: ❒ Benign ❒ Hyperplasia ❒ Atypical Hyperplasia ❒ LCIS

7. What is your race? ❒ Caucasian ❒ African American ❒ Hispanic/Latino ❒ Asian
❒ Ashkenazi Jewish Other_____

Signature: _____ **Date**_____

BETHESDA HEALTH

Cancer Family History Questionnaire

PERSONAL INFORMATION

Patient Name	Date of Birth	Age

Gender (M/F)	Today's Date	Healthcare Provider	Patient Phone Number

You and the following close blood relatives should be considered: YOU, Parents, Brothers, Sisters, Sons, Daughters, Grandparents, Grandchildren, Aunts, Uncles, Nephews, Nieces, Half-Siblings, First-Cousins, Great-Grandparents, and Great-Grandchildren

		TYPE OF CANCER	SELF	MOTHER'S SIDE	FATHER'S SIDE	AGE AT DIAGNOSIS
Y	N	Breast cancer over the age of 50				
Y	N	Breast cancer, 50 or younger				
Y	N	Ovarian cancer at any age				
Y	N	Two breast cancers in one person or on the same side of the family (one diagnosed before age 50)				
Y	N	Male breast cancer at any age				
Y	N	Triple Negative Breast Cancer (ER-, PR-, HER2-), 60 or younger				
Y	N	Three or more breast, ovarian, pancreatic, and/or prostate cancers on the same side of the family				
Y	N	Pancreatic cancer or prostate cancer, AND one relative with breast cancer, 50 or younger				
Y	N	Ashkenazi Jewish ancestry with breast or pancreatic cancer at any age				
Y	N	Colon/rectal cancer, 50 or younger				
Y	N	Endometrial/uterine cancer, 50 or younger				
Y	N	Two or more Lynch syndrome cancers* on the same side of the family (one diagnosed before age 50)				
Y	N	Three or more Lynch syndrome cancers* on the same side of the family				

(*Lynch syndrome cancers: colon/rectal, endometrial/uterine, ovarian, stomach, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain, or sebaceous adenomas)

Y	N	10 or more colon/rectal polyps				
		2 or more melanomas on the same side of the family				
		Melanoma and pancreatic cancer on the same side of the family				

Y N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?

If Yes, Who?_____ What gene(s)? _____What was the result? _____Year tested?_____

OFFICE USE ONLY: Below to be completed by your Technologist

Hereditary Risk Assessment Review

GENETIC EDUCATION PROVIDED (circle one): Test Sent Declined Testing Declined Genetic Education

TYRER CUZICK (IBIS) _____% TECHNOLOGIST SIGNATURE _____