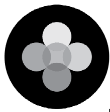
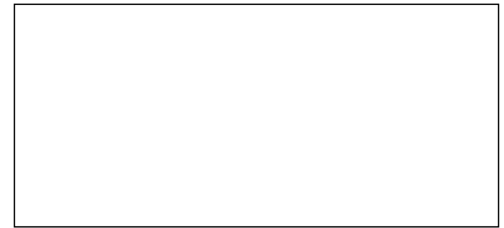


Lakeridge Health

Risk Assessment for Breast Cancer



Name:_______________________ **Date:**_______________

Family Doctor/Nurse Practitioner:_______________________

Height:________feet/inches________cm **Weight:**________lbs________kg

Have you ever been diagnosed with cancer? ☐ No ☐ Yes

If yes, what type(s)?_______________________and at what age(s)? ____________

How old were you when you had your first period?________

Are you (choose one):

- ☐ Premenopausal (having regular periods)
- ☐ Perimenopausal (going through menopause)
- ☐ Postmenopausal (completed menopause at age ________)

Do you have any children? ☐ No ☐ Yes

If yes, what age were you when your first child was born?___________

Have you had surgery to remove your ovaries? ☐ No ☐ Yes

If yes, at what age?____________ Were both ovaries removed? ☐ No ☐ Yes

Have you had your tubes tied? ☐ No ☐ Yes

Have you been diagnosed with endometriosis? ☐ No ☐ Yes

Have you ever had a mammogram? ☐ No ☐ Yes

If yes, where (hospital/clinic)_______________and when (month/year)____________

Have you ever had a breast MRI? ☐ No ☐ Yes

If yes, where (hospital/clinic)_______________and when (month/year)____________

Have you had a breast biopsy? ☐ No ☐ Yes

If yes, where (hospital/clinic)_______________and when (month/year)____________

Have you ever taken the birth control pill? ☐ No ☐ Yes

If yes, at what age?_______________

Have you ever taken hormone replacement therapy (HRT)? ☐ No ☐ Yes

If yes, are you currently taking HRT? ☐ No ☐ Yes, name of HRT medication _______________

How long do you plan to take HRT?______________

What age were you when you started HRT?________and when you stopped HRT?________

Do you have breast implants? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

If yes: I have_____ alcohol drink(s) in a ☐ day ☐ week ☐ month (choose one)