BREAST CANCER RISK ASSESSMENT FORM

MSRM 140117.01.7.1
(R-4/19)

Name: _____ DOC #: _____ Date of Birth: _____

Have form completed and fax to OK Breast Care Center, Stephanie Wimberley at 405-755-1617.

Personal History

Weight _____lbs Height ____'____"

Number of Pregnancies_____ Number of Children_____ Age at first birth_____

Currently Pregnant? ☐ No ☐ Yes Currently Breast Feeding? ☐ No ☐ Yes

Done Childbearing? ☐ No ☐ Yes

Age at first period _____ Still having periods? ☐ No ☐ Yes Age you were when you stopped having periods? _____

Hysterectomy? ☐ No ☐ Yes If Yes, at what age? _____ Ovaries Removed? ☐ No ☐ Yes

Check Menopausal Status: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

Used hormones in the past? ☐ No ☐ Yes How long? _____years

Birth Control

Currently taking? ☐ No ☐ Yes Taken in the past? ☐ No ☐ Yes How many years? _____

Previous Biopsies of any kind?_____

Ethnicity/Origin

Grandparents of Jewish Descent? ☐ No ☐ Yes Race _____

Misc:

Ever taken Tamoxifen or Raloxifene? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes How many years have you smoked in your lifetime? _____

Are you of Hispanic background? ☐ No ☐ Yes

List all family members living or passed.

How many sisters do you have? _____ How many brothers do you have? _____

How many sisters does your mother have? _____ How many brothers does your mother have? _____

How many sisters does your father have? _____ How many brothers does your father have? _____

How many daughters do you have? _____ How many sons do you have? _____

List any members that have had any type of cancer below in the appropriate boxes, including grandparents. If there are more relatives affected with cancer, list on a separate paper.

Name	Relationship	Bloodline	Age of Diagnosis	What Type of Cancer if any.
	Father			
	Grandfather	Paternal		
	Grandmother	Paternal		
	Uncle	Paternal		
	Uncle	Paternal		
	Aunt	Paternal		
	Aunt	Paternal		
	Self			
	Brother			
	Brother			
	Sister			
	Sister			
	Son			
	Daughter			
	Mother			
	Grandfather	Maternal		
	Grandmother	Maternal		
	Uncle	Maternal		
	Uncle	Maternal		
	Aunt	Maternal		
	Aunt	Maternal		

Health Care Provider Signature/Credentials: _____ Date: _____ Time: _____

RN/LPN Signature/credentials: _____ Date: _____ Time: _____