CEDAR VALLEY
Breast Care Center
A branch of CVMS

1753 West Ridgeway Ave., Suite 104, Waterloo, IA 50701

NAME:_____ **DOB:** _____ **DATE**: _____

1. What is your weight? _____ lbs.
2. What is your height? _____ feet _____ inches
3. What age were you at the time of your first menstrual period? _____
4. Have you given birth to one or more children? Yes No
   If yes, what age were you when you delivered your **FIRST** live birth? _____
5. Have you gone through menopause? Yes No If yes, what age? _____
6. Do you **currently** take birth control pills? Yes No If yes, for how long? _____
7. Do you **currently** take hormone replacement therapy? Yes No If yes, for how long? _____
8. Have you **ever used** hormone replacement therapy? Yes No If yes, for how long? _____
9. Any personal or family history of genetic testing? Yes No
   If yes, who was tested and what was the result: _____
10. Have you ever had any breast biopsies done? Yes No
    If yes, which breast? _____ How many? _____ Findings: _____
11. Are you of Ashkenazi Jewish decent? Yes No

PERSONAL or Family History of **Breast, Ovarian or Pancreatic Cancer:** Family includes ***parents, children, siblings, grandparents, aunts, uncles & first cousins.*** Please indicate below any personal or family history and the age when diagnosed.

	Breast Age @ diagnosis	**Ovarian** Age @ diagnosis	**Male Breast Cancer** Age @ diagnosis	**Pancreatic Cancer** Age @ diagnosis
Self				
Your Children				
Siblings				
Mother/ Mother's side				
Father/ Father's side				

Tyrer Cuzick v8: _____% Lifetime Gail Score: _____% 5 year / _____% Lifetime