



**Breast Care Center, A branch of Cedar Valley Medical Specialists,  
1753 West Ridgeway Ave., Suite 104, Waterloo, IA 50701**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

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**Family History of Breast, Ovarian or Pancreatic Cancer:**

Please include parents, grandparents, aunts, uncles, siblings, children & first cousins and age at diagnosis:

	<b>Breast Cancer</b> (age at diagnosis)	<b>Ovarian Cancer</b> (age at diagnosis)	<b>Male Breast Cancer</b> (age at diagnosis)	<b>Pancreatic Cancer</b> (age at diagnosis)
<b>Father/ Fathers side</b>				
<b>Mother/ Mothers side</b>				
<b>Brother(s)/ Sister(s)</b>				
<b>Children</b>				

Tyrer Cuzick v8: \_\_\_\_\_ % Lifetime      Gail Score: \_\_\_\_\_ % 5 year / \_\_\_\_\_ % Lifetime

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_