



## High Risk Cancer Screening Questionnaire

Please take a moment to complete this questionnaire. It will allow us to evaluate your risk factors for developing breast cancer and provide you with appropriate quality medical care.

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Age \_\_\_\_\_

Age at first menstrual period \_\_\_\_\_

Age at first live birth \_\_\_\_\_

Caucasian     African American     Hispanic     Asian     American Indian

***Please check all that apply:***

Personal history of breast cancer. Age diagnosed: \_\_\_\_\_

Personal history of ovarian cancer. Age diagnosed: \_\_\_\_\_

History of Atypical Ductal Hyperplasia, Lobular Carcinoma In-Situ, or Atypical Lobular Hyperplasia:  
     • If yes, please explain: \_\_\_\_\_

History of any breast biopsy:  
     • If yes, how many biopsies? \_\_\_\_\_

Personal history of chest wall radiation between the ages of 10-30 years

Personal or family history of the BRCA gene mutation.

Immediate Family (mother, father, sister, brother, daughter) with history of breast or ovarian cancer:  
     • If yes, how many family members with history of breast cancer? \_\_\_\_\_

Extended Family (aunts, uncles, cousins) with history of breast or ovarian cancer.

Family history of multiple cancers.

Ashkenazi Jewish ancestry.

**Office Use Only**

Gail 5-Year Risk Score: \_\_\_\_\_ %

Gail Lifetime Risk Score: \_\_\_\_\_ %

[Threshold: 5-Year Risk of **1.7** or greater OR Lifetime Risk of **20%** or greater]

Patient's Gail Score meets High Risk criteria: Yes No

• If Yes, patient is placed on High Risk program based upon the following:

- |  |     |    |
|--|-----|----|
|  |     |    |
| • A High Risk consultation was encouraged:             | Yes | No |
| • Patient is aware of risk assessment results:         | Yes | No |
| • Patient chooses to participate in High Risk program: | Yes | No |

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_