

Hereditary Cancer Risk Program

W.H. and Peggy Smith Baylor-Sammons Breast Center
Baylor University Medical Center at Dallas

Family History and Risk Assessment Questionnaire

Please answer questions to the best of your ability in order
to help us establish your risk assessment.
Write in Unk (unknown) for information not known.

If you have any questions or if you need to schedule/change an appointment,
please call **(214) 820-9600**

Please send or fax this completed
questionnaire (page 1 – 6) to us
at least 1 week prior to your appointment
(Fax: (214) 820-9606)

Participant Information

Name: _____
(Last) (First) (Middle)

Address: _____
(Street)

(Zip) (City) (ST)

Phone No:
Home: _____ Work: _____
(area code) (number) (area code) (number)

Cell Phone: _____

Email address: _____

Birth date: _____ Age _____ Social Security No: _____

Spouse Name (optional) _____
(this is for purpose of building your family tree)

When is the best time to contact you? _____

May we email you if we need additional information? _____

Please tell us how to contact you: Work ___ Home ___ email ___ Cell ___

Who referred you to the Hereditary Cancer Risk Program? _____

.....
Office use ID: _____

Other family members in HCRP (office use)	

Your Breast History – all participants, including Males	
Do you have or did you have a history of breast problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:
Have you ever had a breast biopsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many have you had? # _____
Result of <u>last</u> biopsy	<input type="checkbox"/> Benign (no cancer) <input type="checkbox"/> Malignant (cancer): <input type="checkbox"/> In-situ <input type="checkbox"/> Invasive
If you have ever been diagnosed with cancer, please complete the following section	
Cancer – Treatment – all participants, including Males	
Breast Cancer	<input type="checkbox"/> Lumpectomy- Left___ Right ___ age _____
Bilateral? (Cancer in Both Breasts)	<input type="checkbox"/> Mastectomy- Left___ Right ___ age_____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgeon: _____
Age at diagnosis: _____	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other: _____ Oncologist: _____
	<input type="checkbox"/> Radiation therapy Radiation Oncologist: _____
Other Cancer: _____	<input type="checkbox"/> Surgery: _____
Type	<input type="checkbox"/> Other treatment:
Age at diagnosis: _____	Physician: _____

<p>Have you had your Uterus removed?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes, reason:</p>
<p>Have you had your ovaries removed?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> One ovary <input type="checkbox"/> Both ovaries If yes, reason:</p>
<p>Your Lifestyle History – All Participants</p>	
<p>Have you ever smoked cigarettes?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, do you currently smoke cigarettes?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, how many packs per day do you smoke?</i> # _____</p>
<p>Do you ever drink alcoholic beverages?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <i>if yes, how many drinks per week do you consume?</i> # _____</p>
<p>Do you exercise? (If you have cancer, did you exercise before your diagnosis?)</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No • If yes, how many hours per week? _____</p>
<p>Your Health History – All Participants</p>	
<p>Do you have any ongoing health problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Briefly describe any health problems here:</p>
<p>Are there any concerns you would like to discuss during your visit to the Hereditary Cancer Risk Program?</p>	