

14. Have you ever had radiation treatment to your chest (not mammography)?

No Not sure Yes Reason _____

15. Have any of your mammograms shown dense breast tissue?

No Not sure Yes How dense? _____ % Not sure

16. Please indicate whether you or your family members have had any of the cancers listed in the top row of the table by circling yes (Y) or no (N). Provide information about your biological (blood) relatives only, both living and deceased.

	Breast cancer at or before age 50		Breast cancer after age 50		Breast cancer in a male relative		Ovarian cancer		Other related cancers* (please specify)		
Yourself (personal history)	Y	N	Y	N	-----	Y	N	Y	N	_____	
Your parents	Y	N	Y	N	Y	N	Y	N	Y	N	_____
Your brothers & sisters	Y	N	Y	N	Y	N	Y	N	Y	N	_____
Your children	Y	N	Y	N	Y	N	Y	N	Y	N	_____
Your father's parents	Y	N	Y	N	Y	N	Y	N	Y	N	_____
Your mother's parents	Y	N	Y	N	Y	N	Y	N	Y	N	_____
Your father's brothers & sisters	Y	N	Y	N	Y	N	Y	N	Y	N	_____
Your mother's brothers & sisters	Y	N	Y	N	Y	N	Y	N	Y	N	_____

*Other related cancers include thyroid cancer, endometrial cancer, bone or soft tissue cancer, sarcoma, adrenocortical carcinoma, brain cancer, diffuse gastric cancer, and early onset acute leukemia.

17. If you answered yes to having a personal history of breast cancer, what treatments did you have? (If you have not had breast cancer, skip to 18)

Surgery: Lumpectomy Mastectomy Circle one: Lt Breast Rt Breast Both Breasts
 Radiation
 Chemotherapy
 Hormones
 Other: _____

18. Have you ever had breast surgery for reasons other than breast cancer (implants, reduction, other)?

No Not sure Yes Circle all that apply: Implants Breast Reduction Other

19. Have you or a family member tested positive for a mutation in a breast cancer susceptibility gene?

No Not sure Yes What gene(s)? _____ Not sure

20. Do you have Ashkenazi Jewish ancestry?

No Not sure Yes