Washington State Department of Health

SPOKANE REGIONAL HEALTH DISTRICT
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Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

DOH 349-043 Nov 2019

Breast and Cervical Risk Assessment Form – One Page

Please Print **BCCHP ID#** **Authorization #**

Last Name:	**First Name:**	**MI:**	**Date of Birth**	**Date:**

Clinic/Screening Site: **Provider:**

Health Insurance: ☐ No ☐ Yes: If "Yes", company: Policy/ID #: Deductible Amount: :$

Tobacco use: Current smoker? ☐ Yes ☐ No ☐ Never Smoked If "Yes", ever counseled to stop? ☐ Yes ☐ No

What is your gender identity? (Optional)
☐ Female ☐ Male ☐ Transman ☐ Transwoman
☐ Genderqueer ☐ Gender Non-Binary ☐ Agender ☐ _____

Disability? ☐ No ☐ Yes ***Circle all that apply*** Physical, Hearing, Visual, Developmental ☐ Other (specify):
If "Yes", does this cause difficulty in accessing services? ☐ Yes ☐ No

****PROVIDERS MUST COMPLETE SECTIONS BELOW THIS LINE****

CERVICAL HEALTH HISTORY

Previous Pap Test?
☐ Yes ☐ No ☐ Unknown
If "Yes", Date of previous Pap test:
Results: ☐ Normal ☐ Abnormal ☐ Unknown

Has the patient had a Hysterectomy?
☐ Yes, *Date of hysterectomy:* ☐ No ☐ Unknown
If "Yes", reason for hysterectomy:
☐ CIN2/3 or cervical cancer ☐ Not cancer ☐ Unknown
Does the patient have a cervix? ☐ Yes ☐ No ☐ Unknown

Personal History
Abnormal Paps? ☐ Yes ☐ No ☐ Unknown
History of HPV? ☐ Yes ☐ No ☐ Unknown
HIV Positive? ☐ Yes ☐ No ☐ Unknown
Did mother take Diethylstilbestrol (DES) when pregnant with patient?
☐ Yes ☐ No ☐ Unknown
Is the patient Immunocompromised due to organ transplant or an autoimmune disease like Systemic Lupus Erythematous, and taking immunosuppressive medications?
☐ Yes ☐ No ☐ Unknown

***Cervical Cancer Risk:** ☐ Average ☐ High ☐ Not Assessed

If high, indicate reason: _____

BREAST HEALTH HISTORY

Previous Mammogram?
☐ Yes ☐ No ☐ Unknown
If "Yes", Date of previous Mammogram:
Results: ☐ Normal ☐ Abnormal ☐ Unknown
Does patient breast implants? ☐ Yes ☐ No
Family history of breast cancer 1˚ relative
(Mother, father, sister, brother, daughter or son)?
☐ Yes ☐ No ☐ Unknown *If "Yes", Age:*
BRCA 1 or 2 carrier-self ☐ Yes ☐ No ☐ Unknown
BRCA 1 or 2 1˚ relative carrier ☐ Yes ☐ No ☐ Unknown
Personal breast cancer history? ☐ Yes ☐ No ☐ Unknown *Age:*
Personal history of a pre-cancerous breast condition?
☐ Yes ☐ No ☐ Unknown *If "Yes", Age :*
Has patient ever given birth? ☐ Yes ☐ No
Age of first full-term pregnancy?
Indicate if chest wall radiation before 30 ☐ Yes ☐ No

***Breast Cancer Risk:** ☐ Average ☐ High ☐ Not Assessed

If high, Tyrer-Cuzick (IBIS) model used**:** ☐ Yes ☐ No
Other tool used (Gail model not accepted by BCCHP):_____
Lifetime Risk:_____**%** (20% or higher is considered high risk)

Refer for Mammogram: ☐ Yes ☐ Not indicated ☐ Refused

Reason for Mammogram:
☐ Routine Screen
☐ Evaluate symptoms/abnormal finding, abnormal mammogram
☐ Referred by non-BCCHP provider for diagnostic evaluation

Referred to:

If referring a patient at high risk for breast cancer for MRI, Lifetime risk calculation is required (Gail model not accepted)
Tyrer-Cuzick (IBIS) model used**:** ☐ Yes ☐ No
Other tool used:_____
Lifetime Risk:_____**%** (20% or higher is considered high risk)

For persons with disabilities, this document is available on request in other formats.
To submit a request, call 1-800-525-0127 (TDD/TTY call 711)