IBCCP Health Assessment

Name: **Date:**

YES	NO	BREAST HEALTH QUESTIONS
☐	☐	1. Do you routinely check your breasts for changes?
☐	☐	2. Have you noticed a lump in your breasts?
☐	☐	3. If yes, which breast? Right___ Left____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
☐	☐	6. If you answered yes to question #4, which breast? Right ________ Left______
☐	☐	7. Have you noticed any spontaneous discharge (not from stimulation or squeezing) from your nipples?
☐	☐	8. If yes, which breast? Right ________ Left______
☐	☐	9. Have you noticed any other symptoms related to your breasts? If yes, explain: ________________________
☐	☐	10. Have you ever had a breast exam done by a doctor or nurse?
☐	☐	11. If yes, list provider/clinic where breast exam was done: ______________________
☐	☐	12. If yes, date of last exam (before this current visit): _____/_____
☐	☐	13. Have you ever had a mammogram?
☐	☐	14. If yes, list provider/clinic where mammogram was done: ___________________________
☐	☐	15. If yes, date of your last mammogram (before this current visit):___/_____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, father, sibling (sister/brother), daughter or son had breast cancer? If no, go to question 22.
☐	☐	19. If yes to #18, who __________________________
☐	☐	20. Are they BRCA positive (if unknown leave blank)?
☐	☐	21. If yes to #18, at what age? __________ years old
☐	☐	22. Do you have a breast implant or implants?
☐	☐	23. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
☐	☐	24. If yes, which breast? Right ________ Left______
☐	☐	25. If yes, list the provider who performed the procedure_____________________
☐	☐	26. Have you ever had radiation to the chest area?

YES	NO	CERVICAL HEALTH QUESTIONS
☐	☐	27. Have you ever had a Pap test?
☐	☐	28. If yes, list provider where Pap test was done: ___________________________
☐	☐	29. If yes, date of last Pap test: (before this current visit) ___/____
☐	☐	30. If date unknown, was it more than 10 years ago? Please guess and write the date in #29.
☐	☐	31. Were your last Pap test results normal?
☐	☐	32. What was the date of your last menstrual period? _____/_____/_____
☐	☐	33. Are you pregnant?
☐	☐	34. Have you had a hysterectomy?
☐	☐	35. If yes, was your cervix removed? I do not know_____
☐	☐	36. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?
☐	☐	37. Were you exposed to Diethylstilbestrol (DES)?
☐	☐	38. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)

YES	NO	TOBACCO QUESTIONS
☐	☐	39. Do you smoke cigarettes?
☐	☐	40. If yes, are you ready to quit smoking?
☐	☐	41. If yes, are you interested in being referred to the Illinois Tobacco Quitline?

(Shaded area for IBCCP office use)

42. What date was the referral sent to the Tobacco Quitline? ____/____/____

BARRIER/RISK ASSESSMENT QUESTIONS

Barrier Assessment

43. from Eligibility Determination form

Breast Cancer Risk Assessment

(from Summary Office Visit form)

44. Life time risk_______

45. High risk for breast cancer
- ☐ yes, client is high risk
- ☐ no, client is not high risk
- ☐ not assessed/unknown

Cervical Cancer Risk Assessment

46. High risk for cervical cancer
- ☐ yes, client is high risk
- ☐ no, client is not high risk
- ☐ not assessed/unknown