Breast Cancer Risk Assessment Questionnaire

Name _____ Age _____

Are you still cycling - Yes No If not how many months years ago did you stop? _____

YES NO	Do you have a family history of Breast Cancer? (Grandmother, Mother, Sister, Aunts)
YES NO	Do you or have you used oral contraceptives or hormone replacement therapy?
(0) - (1-2) - (3+)	How many children have you given birth to?
YES NO	Did you have your first child before the age of 21?
YES NO	Do you have a history of any cyclical issues such as: cyclical breast tenderness, endometriosis, uterine Fibroids, Fibrocystic Breast, PMS / PMDD or have you been diagnosed or told that you were "estrogen dominant"?
YES NO	Are you hypothyroid or suspect to be hypothyroid?
YES NO	Are you diabetic or pre- diabetic or do you have blood sugar control issues?
YES NO	Do you ever microwave food or drinks in any plastic containers or cover it with plastic wrap in the microwave?
YES NO	Do you drink coffee or other hot beverages from a Styrofoam cup?
YES NO	Do you use or have you used commercial weed killers such as "Roundup" or Insecticides in your home garden or workplace?
YES NO	Do you use progesterone cream or patches?
YES NO	Do you consume at least 3 servings of cruciferous vegetables per week? (Kale, Brussels Sprouts, Broccoli, Cauliflower)
YES NO	Do you get at least 20 minutes of aerobic exercise at least 3 times per week?
YES NO	Do you know if you have adequate vitamin D levels?
YES NO	Do you know if you have adequate iodine levels?
YES NO	Do You regularly consume Non – Organic Dairy products (milk, cheese, etc) or non-organic meat or chicken?
YES NO	Do you use over the counter or prescription antacid medications? Pepcid, Prilosec, Tagamet, Protonix, etcetera?
YES NO	Do you or have you used circle all that apply: Tylenol / *acetaminophen, caffeine, Aleve,*
YES NO	Do you consume alcohol? How much _____ wk
YES NO	Do you consume caffeine? How much _____wk
YES NO	Do you or have you used circle all that apply: Antidepressants, Anti Spasmodics, Anti-Fungals, Antibiotics, Beta Blockers, Anti-inflammatories, Interferon, Hypertension medications. Blood thinners, Asthma medication (theophylline),
YES NO	Do you regularly consume vegetables such as Beets, Radish, Lentils and Onions?
YES NO	Is your BMI (body mass index) fat over 30%?
YES NO	Have you had your 2 / 16 estrogen ratio evaluated?