THE BATON ROUGE CLINIC AMC
Caring for Generations
Established 1946

BREAST CANCER GENETIC VARIANT RISK ASSESSMENT

Date:_____

Name:_____ DOB:_____

Allergies: _____

Medications: may use printed list if you have one

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Over the counter medications, supplements, vitamins:

_____
_____
_____
_____
_____
_____
_____

Prior breast surgery or procedures:

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_____
_____
_____
_____
_____

Last mammogram: month/year and
location:_____

Primary Care Doctor:_____

Gynecologist:_____