

The Chi Farm Acupuncture Clinic, Publications and Seminars

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Breast Cancer Risk Assessment Questionnaire

Name _____ Age _____

Are you still regularly cycling? ___ Yes ___ No. If not how many years ago did you stop? _____

YES	NO	Do you have a family history of breast cancer (grandmother, mother, sister, aunt)?
YES	NO	Do you or have you used oral contraceptives or hormone replacement therapy?
(0) - (1-2) - (3+)		To how many children have you given birth?
YES	NO	Did you have your first child before the age of 21?
YES	NO	Do you have a history of any cyclical conditions (circle which): 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 suspected 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 or have you used commercial weed killers such as “Roundup” or Insecticides?
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, rotonix, etc.)?
YES	NO	Do you or have you regularly used (circle which ones): Tylenol/acetaminophen, caffeine, Aleve?
YES	NO	Do you regularly consume alcohol? If yes, how much in a typical week? _____
YES	NO	Do you regularly consume caffeine? How much If yes, how much in a typical week? _____
YES	NO	Do you or have you used {circle all that apply): antidepressants, antispasmodics, anti-fungals, antibiotics, Beta-blockers, anti-inflammatories, interferon, hypertension medications. Blood thinners, Asthma medication?
YES	NO	Do you regularly consume vegetables such as Beets, Radish, Lentils and Onions?
YES	NO	Is your body fat over 30%
YES	NO	Have you had your 2 /16 estrogen ratio evaluated?