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Assessment of Nurse Practitioner Management of Breast Cancer Screening

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**SAN JOSE STATE UNIVERSITY
SCHOOL OF NURSING****MASTER'S PROGRAM PROJECT OPTION (PLAN B)
PROJECT SIGNATURE FORM**

STUDENT NAME

Renée M. Cormie

SEMESTER ENROLLED

Spring '99

TITLE OF PROJECT

Assessment of NP management
of Breast Cancer Screening

The project and manuscript have been successfully completed and meet the standards of the School of Nursing at San Jose State University. The project demonstrates the application of professional knowledge, clinical expertise, and scholarly thinking. An abstract of the project and two copies of the manuscript are attached.

Jan Sullivan
ADVISOR SIGNATURE5/17/99
DATE*Gigi Jordan*
ADVISOR SIGNATURE5/28/99
DATE

Please submit this form to the Graduate Coordinator. Attach the abstract, two copies of the manuscript, and documentation of submission to the journal.

ASSESSMENT OF NURSE PRACTITIONER MANAGEMENT
OF BREAST CANCER SCREENING

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Abstract

The purpose of this study was to examine current practice behaviors of adult nurse practitioners when assessing and screening asymptomatic women over age 50 for breast cancer. Rosenstock's Health Model and Bandura's social learning theory guided this research. One hundred-fifty nurse practitioners were surveyed by questionnaire. Seventy-six surveys were completed and returned. Survey results revealed that those practitioners who had experienced breast cancer themselves were more aggressive in their screening and follow-up practices than those who had never had breast cancer. It was also noted that the nurse practitioners surveyed were performing initial breast cancer screening but not having patients return each year for on-going assessment. Stressing the need for yearly breast care is essential in detecting changes early enough to improve the chance of survival should problems be identified. Women over age 50 are at greater risk for breast cancer. Mortality rates are greatly affected by what stage the cancer is in when it is detected. Therefore, aggressive teaching and on-going screening are essential in contributing to the survival rate and breast health of women over 50. The knowledge gained from this research may increase nurse practitioners' awareness of the importance of consistent yearly screening after an initial evaluation.

Assessment of Nurse Practitioner Management
of Breast Cancer Screening
The Problem

Breast Cancer

According to the American Cancer Society (ACS), 178,700 women will be diagnosed with breast cancer this year, and 43,500 will die (1997). At the present rate, the ACS predicts that one out of every eight women will develop breast cancer in her lifetime. While all women are at risk for cancer of the breast, the risk does increase with age. Eighty percent of all breast cancers are found in women over age 50 (Kopans, 1994). Kopan's research reveals that the mortality rate could be decreased by 30% if all women age 50 and older in need of a mammogram had one. Current ACS guidelines recommend that women age 20 to 39 should have a clinical breast exam (CBE) as part of routine medical care every 2 to 3 years, and women age 40 to 49 should have yearly CBE and mammography every 12 to 24 months. The ACS recommended standard of care for women age 50 and over is yearly CBE and mammography. How to perform a monthly breast self-exam (BSE) should be taught to each woman over the age of 20 (Leitch, 1998).

Prevalence and Possible Causes of Breast Cancer

The prevalence of breast cancer has increased progressively throughout the world with the most substantial increases occurring in groups that previously had low incidences of breast cancer. The United States has one of the highest incidences and the rate is particularly increasing in women under 40 (Kopans,

1994). Various factors have been proposed to explain changes in breast cancer occurrence including (a) delayed childbearing, (b) diet, (c) hormonal influences, (d) an aging population, and (e) increased detection (Kopans).

Variables Associated with Breast Cancer

In recent years, clinical and epidemiological studies by the ACS (1997) have identified several variables associated with the occurrence of breast cancer. In Western countries an increase in breast cancer occurs with increasing age. The incidence of breast cancer also varies geographically, with the highest rates in North America and northern Europe, intermediate rates in southern Europe and South America, and the lowest rates in Asia and Africa (ACS). Factors thought to increase a woman's risk of developing breast cancer are (a) history of cancer of the breast in a mother, sister and/or daughter, (b) histologically confirmed proliferative breast disease with atypia, (c) age greater than 35 at time of first live birth, (d) nulliparity, (e) early menarche, (f) late natural menopause, (g) radiation exposure, (h) breast cancer susceptibility genes, (i) higher socioeconomic status, and (j) a history of ovarian or endometrial cancer (ACS). Other less well-documented but probable risk factors include (a) alcohol use, (b) high-fat/low-fiber diets, (c) higher postmenopausal weight, (d) anovulatory menstrual cycles, and (e) immune deficiency (ACS). The use of exogenous estrogens and their role in promoting breast cancer remains controversial. Although risk factors should be considered to put some women at an increased susceptibility, breast cancer is so prevalent that it is

advisable to consider all women at risk. Approximately 50% of breast cancers occur without risk factors (Leitch, 1998).

Breast Cancer and Survival Rates

Most women who are diagnosed with breast cancer will survive the disease, however, early detection is the key (Leitch, 1998). Of the 75% of breast cancer cases that are detected by women themselves during BSE, 50 to 55% are stage II or greater at the time of diagnosis (Leitch). The 5-year survival rates decrease according to the stage at detection with stage I at 95%, stage II at 60%, stage III at 41%, and with stage IV disease patients at only a 10% chance of survival (Leitch). Leitch also states that despite changes in the treatments for breast cancer, the age-specific mortality rate for white women has not changed significantly in the past 10 years but has been increasing in non-white women.

Nurse Practitioners and Breast Cancer

In the absence of dramatic improvements in survival for a given breast cancer stage and in the absence of an effective way to prevent primary disease, attention should be focused on early detection. Although many factors including (a) age, (b) menopausal status, (c) hormone receptor status, (d) tumor histology, and (e) cellular kinetics are important determinants of survival, tumor stage at the time of diagnosis is the most important documented prognostic factor at this time (Leitch, 1998). Given the encouraging survival rates if detected in the early stages, it is imperative that nurse practitioners (NPs)

providing primary care to women, aggressively screen for breast cancer using CBE, mammography, and promoting BSE.

Purpose and Significance of the Study

The purpose of this research was to survey the practice behaviors of NPs in the management of breast cancer screening of asymptomatic females over age 50. The knowledge gained from this study may identify gaps and inconsistencies in the techniques used by NPs to enhance the breast health of these women.

Background Literature Review

A number of mass screening programs consisting of physical and mammographic examination of the breasts of asymptomatic women have been conducted. Feig (1995) found that such programs frequently identify about 10 cancers per 1000 women older than age 50. Feig's study revealed that about 80% of these women had negative axillary nodes at the time of surgery, whereas only 45% of non-screened women found in the course of routine exam had uninvolved nodes. The author showed that detecting breast cancer before it had spread to the axillary nodes greatly increased the chances of survival, and about 95% of such women would go on to live at least 5 years.

Breast Cancer Screening

A 1996 study of 1000 asymptomatic women over age 50 by Mettler showed that both physical exam and mammography are necessary for maximum yield in screening programs. Mettler found that 35 to 50% of early breast cancers can be discovered only by mammography, and another 40% can be detected only by palpation. When abnormalities detected in the screening mammograms in

Mettler's study were biopsied, approximately a third were found to be malignant.

Taber (1995) found the sensitivity of mammography to vary between 60 to 90%. This, Taber stated, was dependent upon such factors as (a) patient age, (b) tumor size, (c) location, and (d) mammographic appearance. According to Taber, in young women with dense breasts, mammography is less sensitive than in older women with fatty breasts, in whom mammography can detect at least 90% of malignancies. Taber goes on to say that smaller tumors, particularly those without calcifications, are more difficult to detect in general and again, this makes identification of changes in the denser breasts of the non-menopausal woman problematic. The specificity of mammography in women under age 50 varies from 30 to 40% for non-palpable mammographic abnormalities and 85 to 90% for clinically evident malignancies.

McPherson, Swenson, Jolitz, and Murray (1997) examined the survival rates of women aged 50 to 59 with breast cancer according to the method of detection. They studied 971 women diagnosed with invasive breast carcinoma between 1986 and 1992 as identified by The Upper Midwest Oncology Registry Services (TUMORS). Measures of tumor size, lymph node status, and overall survival were compared with breast cancer patients whose tumors were detected by BSE, CBE, or mammography (McPherson et al.). The authors found mean tumor size among women in the mammography group was smaller than that among women in the BSE and CBE groups. Women whose tumors were detected by mammography had

significantly better survival than women in whom tumors had been detected by BSE or CBE alone.

An examination of screening studies adds to the controversy regarding the benefits of screening in women younger than 50. According to Leitch (1998) an examination by the National Cancer Institute (NCI) revealed that out of eight randomized age-specific screening studies, only one demonstrated a beneficial effect for women between the ages of 40 to 49. This benefit was seen between 10 and 18 years after entry into the study and resulted in a 25% decrease in deaths from breast cancer (Leitch). After 12 years of follow-up, however, NCI reported this decrease was not statistically significant. In the meta-analysis of five randomized trials study by the NCI, the breast cancer death rates were virtually identical in women age 40 and 49 whether screened or not (Leitch). The NCI's research concluded that the beneficial effects of screening women age 50 to 69 was undisputed and confirmed by all clinical trials (Leitch).

Once the NCI study was published, there was general agreement that women age 50 and over should have an annual physical exam that combines review of BSE, a CBE, and most importantly, a mammogram (Leitch, 1998). This strategy has been adopted by the NCI, ACS, and the American College of Radiology.

Barriers to Screening

Insurance coverage.

Several factors have been looked at as barriers to women having regular breast screening. Faulkner and Schauffler (1997) examined the effect having health insurance coverage had on women

seeking yearly preventive services. Their study found that having insurance coverage was one of the most important factors influencing the use of preventive services. Having insurance directly affected the patients' financial access to care and the providers' incentive to give care. The authors went on to find that lower levels of insurance coverage raised the price paid by patients and as price increased, utilization declined.

Faulkner and Schaufler (1997) surveyed 10,643 women aged 40 to 64 whose health insurance covered either (a) all, (b) most, (c) some, or (d) no preventive services. Among the women who reported having all preventive services covered, 95% utilized their insurance for a CBE and mammogram (Faulkner & Schaufler). This finding was in comparison to the 33% utilization rate for women who reported having no preventive insurance coverage (Faulkner & Schaufler).

The impact of poverty and race on screening.

A 1989 study by Freeman stated that a disproportionately greater number of cancer cases and deaths are among the socioeconomically disadvantaged. Freeman characterized poverty as increasing the chances of getting breast cancer and diminishing the chances of survival because it (a) creates an inadequate physical and social environment, (b) discourages the acquisition of information and knowledge, (c) encourages risk-promoting lifestyles, and (d) reduces access to health care. Freeman pointed out that a disproportionate percentage of the poor are members of minority groups whose status is reflected in higher cancer incidences and poorer survival rates with this disparity

being particularly large in African American populations. Freeman stated that while African Americans comprised only 12% of the total population, they represent about a third of the poor. In addition, the author discovered that while the cancer incidence rate increased only by 12% for white women, the rate increased over 27% for African American women over the last several decades. Similarly, while mortality rates for white women increased only by 10%, mortality rates increased for African American women by 40% in the same time period (Freeman). African Americans, the author stated, were more likely to have breast cancer diagnosed at a later stage.

Paskett, Rushing, D'Agostino, and Tatum (1997) conducted a survey of 300 predominately African American women who were residents of a low-income housing community. Their research revealed that more white women than African American women (52% vs. 40%) had received a mammogram as well as a CBE (60% vs. 36%) within the last year. The authors found that among the African American women, the barriers to breast cancer screening most often cited were (a) family or work responsibilities, (b) lack of time, (c) no perceived risk of breast cancer, (d) lack of access to a health care facility, and (e) cost.

Screening and age.

In 1997, a study by Caplan examined the disparities in breast cancer screening based upon a woman's age. According to Caplan, approximately 48% of newly diagnosed breast cancers occur in women 70 and over, while nearly 57% of the breast cancer deaths occur in these same women. The author went on to say that

elderly women are no more likely to have poorer prognostic factors that are associated with early relapse or shorter survival than younger women. Caplan's research considered that since the population was aging and given the increased incidence and mortality of breast cancer in the elderly, it was important that women in their mid-70s be given every opportunity to live out their remaining years in good health.

Caplan's (1997) study revealed that despite all the reasons for detecting problems early through regular screening, it was the elderly who were far behind in receiving testing. The author reviewed data from the 1992 National Health Interview Survey and noted that while only 5% of women aged 50 to 74 had never heard of yearly screening recommendations, 25% of women aged 75 and older reported no knowledge of such recommendations. Further results in the data Caplan reviewed showed that 50% of women aged 50 to 64 had received a mammogram and CBE within the last year compared with 28% of women aged 75 and older. Caplan determined that the two factors influencing the disparity in screening practices between elderly and younger women, given published guidelines, were (a) elderly women did not know they should have a mammogram and (b) their physicians did not recommend it.

Caplan (1997) then surveyed physicians as to why they did not discuss screening with their elderly patients and found reasons such as (a) the low priority of mammography given the other disorders and problems in the elderly, (b) a lack of time, (c) a feeling that increased life expectancy is not worth the cost, and (d) a belief that the elderly patient may not survive

the treatment options should a problem be discovered. Caplan concluded that believing a women too old when it came to screening for breast cancer was unethical and that because women were living longer, more productive lives than ever, each woman should be treated as an individual, not as a category.

Conceptual Framework

The conceptual frameworks that guided this research were Rosenstock's (1974) Health Belief Model and Bandura's (1985) social learning theory. The Health Belief Model (as cited in Glanz et al., 1990) suggests that a woman would be most likely to obtain a mammogram if she believes that (a) she is vulnerable to breast cancer, (b) breast cancer is a serious disease, (c) she can have breast cancer without symptoms, (d) mammography is an effective method of early detection, (e) early detection of breast cancer increases the probability of cure, and (f) the benefits outweigh any barriers or costs involved. According to the social learning theory, increased self-efficacy in seeking breast care should increase the likelihood of receiving such care (Bandura). This theory identifies self-efficacy as having two parts (a) women must first believe that the screening test itself is beneficial and (b) that she can actually obtain the test (Bandura). Research conducted on care provider attitudes suggest that these attitudes play a powerful role in motivating adherence behavior (Fishbein, 1975).

The nursing process was the organizing structure for the questionnaire. This process gave a clear, concise way to compile the survey data.

Research Methodology

Research Design

The method used to gather data for this study was a nonexperimental, descriptive survey. The questionnaire was non-psychometric.

Protection of Human Subjects

Approval from San Jose State University's (SJSU) Institutional Review Board (IRB) was obtained prior to mailing a cover letter (Appendix A) and questionnaire (Appendix B). The IRB was assured the survey would not be coded by name or number so that confidentiality could be maintained. The IRB was informed that the survey results would be destroyed after the research was completed. Participants in the survey were instructed to contact the IRB in the event of a research related injury.

Survey Subjects

The data were obtained by using a convenience sample of 150 adult NPs who were members of the California Coalition of Nurse Practitioners (CCNP). The NPs were mailed the cover letter, questionnaire, and a pre-stamped return envelope. The questionnaire asked the subjects to self-report their practice behaviors when screening asymptomatic women over age 50 for breast cancer.

Seventy-six NPs returned the questionnaire (49%). All seventy-six respondents were female. Ages ranged from 26 to 62 years, with a mean age of 34.6 years. Years employed as an NP ranged from 2 to 25 with a mean of 13.7. Four NPs (6%) were educated in diploma schools, 13 NPs (18%) had Associate Degrees

in Nursing, 10 NPs (14%) held Bachelor's Degrees, and 49 NPs (65%) were Master prepared NPs. Sixty-six NPs (87%) reported performing monthly BSE and 19 NPs (25%) over the age of 50, reported having yearly CBEs and mammograms. Nine NPs (12%) stated that they had a previous personal history of breast cancer, while 3 NPs (4%) reported that they currently had breast cancer.

Instrument

The questionnaire's items were based on a review of current literature related to the assessment and breast cancer screening recommendations of asymptomatic women over the age of 50. The framework of the questionnaire was based on the nursing process of (a) assessment, (b) planning, (c) implementation, and (d) evaluation. The assessment section covered NPs' awareness of the need for a baseline exam and history. The planning section asked questions about NPs' patient teaching behaviors. The implementation items focused on NPs' compliance with recommendations to maintain healthy breast-care habits. Lastly, the evaluation section dealt with the availability of the NPs to their patients after a breast evaluation and their follow-up practices. There were two to five questions in each section of the survey.

Two NPs and one physician considered experts in breast cancer screening were asked to evaluate the newly constructed tool for content and validity. One NP expert was the co-founder of a breast clinic in a large San Francisco Bay Area hospital as well as a breast cancer survivor. The other NP expert was certified as an instructor for the Breast Cancer Early Detection

Program (BCEDP) of California. In addition, this NP expert had extensive experience in surveying practice behaviors. The physician expert was co-director of the local office of the BCEDP. The NPs and physician each determined that the research tool was effective. No revisions to the instrument were made.

Results of the Study

The NPs reported seeing 5 to 100 female patients over age 50 per month. The mean number of women seen was 31. The following tables show the percentage of NPs' responses regarding their practice behaviors when they are screening for breast cancer in the asymptomatic woman over 50. As demonstrated in Table 1, 32% of NPs never assessed for breast cancer at every visit and 69% always assessed the patient during a complete physical exam. Only 31% of NPs were obtaining a complete breast health history and 79% were sometimes assessing their patients' need for BSE teaching materials. NPs who currently had a personal history of breast cancer were noted to have 100% compliance with initial screening recommendations.

Table 1

NP Breast Cancer Screening Practice Behaviors

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Performing CBE at every visit	32%	24%	45%	0%
Performing CBE only during a Complete Physical	0%	14%	19%	69%

(table continues)

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Obtaining a complete breast health history	0%	11%	60%	31%
Assessing patient need for BSE teaching materials	4%	79%	18%	0%

(N=76)

(Note: Table totals do not equal 100% due to rounding)

Table 2 shows that 25% of NPs were always involving their patients in managing their breast health. Twelve percent of NPs were always educating their patients about health care habits.

Table 2

NP Teaching Behaviors

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Involving patients in managing their breast health	0%	37%	39%	25%
Education about healthy breast care habits	0%	11%	78%	12%

(N=76)

Table 3 demonstrates that 10% of NPs never taught their patients BSE and that only 15% of the NPs were always having patients return every 12 months for a CBE and mammogram after a baseline exam. NPs with a personal history of breast cancer reported always having patients return every 12 months for follow-up testing.

Table 3

NP Compliance with Breast Cancer Screening Guidelines

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Teaching patients BSE	10%	19%	50%	23%
Providing a CBE and Mammography every 12 months	6%	24%	60%	12%
Having patients return every 12 months for CBE and mammography	0%	50%	36%	15%
Referral of patients to a breast clinic (N=76)	16%	62%	23%	0%

As shown in Table 4, twenty percent of NPs were never available by telephone for breast health questions. Fifty-eight percent were, however, often following-up by telephone to discuss breast test findings with their patients.

Table 4

NP Follow-Up Behaviors

	<u>Never</u>	<u>Sometimes</u>	<u>Often</u>	<u>Always</u>
Availability by phone for breast health questions	20%	52%	21%	8%
Follow-up by phone to discuss test findings	0%	37%	58%	6%
(N=76)				

Discussion and Recommendation

All of the NPs who responded to the survey reported having asymptomatic women over the age of 50 in their practice. However, not all of these women were afforded screening techniques and methods on a consistent basis. The current standard of care is for monthly BSE, yearly CBE and mammography for these women. It is also recommended to have women return every 12 months after a baseline exam (Leitch, 1998). While 50% of NPs reported this as sometimes their practice habit and 15% always had patients return annually, the remaining NPs who did not may defeat the purpose of yearly screening. Annual follow-up screening could detect changes early enough to affect survival should a malignancy be discovered. The survey participants were not asked why they were not having patients return, so additional factors such as cost, or managed care, were not addressed. Another area in need of

improvement was in providing teaching materials, such as the ACS guide to BSE. Only 12% of NPs always handed out materials and only 18% even assessed their patients' need for written teaching aids. Another practice behavior demonstrated by 14% of respondents was never performing a CBE during a complete physical exam. Again, respondents were not asked why they were not examining their patients' breasts, but perhaps some practitioners adhere to having breast health managed every 1 to 2 years by gynecologists. Preventive health care maintenance is the cornerstone of NPs practice. These activities should not be delegated to other specialties especially when the skills of NPs could greatly benefit patients.

Follow-up care was identified as an area where NPs could greatly improve. Twenty-percent reported they were never available to their patients to discuss breast health. This lack of communication between the NP and the patient decreases the influence the NP has on the patient maintaining healthy breast habits.

Limitations of the Study

Study limitations include (a) a small sample size, (b) use of a convenience sample rather than randomization, (c) participants' reluctance to self-report, and (d) the use of a new survey tool with no established psychometric properties. These factors and the potential that respondents may differ from non-respondents affect the ability to generalize the study to a larger population.

Implications for Nursing

Preventive health care maintenance is fundamental in the curriculum of all NPs. Encouraging, educating, and supporting all women in their health care needs should be incorporated into the practice of every NP who cares for women. Breast health should be no exception. The scientific knowledge of NPs coupled with consistent compliance with established breast cancer screening guidelines, could offer some protection against needless suffering from advanced disease.

At this time it is impossible to predict who will get breast cancer and who will not. NPs can significantly contribute to women's health by promoting screening and education. Perhaps someday, cancer of the breast will no longer be such a threat to current and future generations of women. Until that day however, NPs should be playing a key role in the early detection of this devastating disease.

Appendix A

Cover Letter

Dear Nurse Practitioner:

I need your help in evaluating nurse practitioner's practice behaviors in the management of cancer screening in women over the age of 50. The results of this survey may identify gaps or inconsistencies in the management of women's breast health. Attached is a questionnaire asking about your practice behaviors, using the nursing process, in managing the breast health of women over age 50. Please complete the survey and return it in the pre-paid envelope.

You should understand that your participation is voluntary and that choosing not to participate in this study, or in any part of this study, will not affect your relations with San Jose State University or the California Coalition of Nurse Practitioners. Completing and returning the questionnaire implies that you have consented to participate in this research.

There are no anticipated risks and/or benefits to you if you choose to participate in this survey. The results of this study may be published, but any information that could result in your identification will remain confidential.

If you have any questions about this study, I will be happy to talk with you. I can be reached at [REDACTED]. If you have any questions or complaints about research subjects' rights, or in the event of a research related injury, please contact Jayne Cohen, DNSc., Acting Director of Nursing at [REDACTED] or

Nabil Ibrahim, Ph.D., Acting Associate Vice President for
Graduate Studies and Research, at [REDACTED].

Sincerely,

Renee M. Comee RN

Master of Nursing Science Degree Student

Family Nurse Practitioner Program

San Jose State University

Appendix B

Questionnaire

Please circle the answers that best apply to you. When you are done, return your completed survey in the enclosed postage-paid envelope. Thank you in advance for your participation.

THE FOLLOWING QUESTIONS ARE BASED ON YOUR ASYMPTOMATIC FEMALE PATIENT POPULATION OVER THE AGE OF 50.

Assessment

1. How many women over the age of 50 do you see in one month?___
2. Do you do a CBE at every visit? Never Sometimes Often Always
3. Do you only do a CBE during a
 complete physical exam? Never Sometimes Often Always
4. How often do you obtain
 your patients breast
 health history? Never Sometimes Often Always
5. How often do you assess
 your patient's need for
 BSE teaching materials? Never Sometimes Often Always

Planning

1. How often do you involve
 your patients in manage-
 ing their breast health? Never Sometimes Often Always

2. How often do you discuss
the adoption of healthy
breast habits?

Never Sometimes Often Always

Implementation

1. How often do you teach BSE?

Never Sometimes Often Always

2. Do you give written infor-
mation to your patients?

Never Sometimes Often Always

3. Do you do a CBE and
referral for mammography
every 12 months?

Never Sometimes Often Always

4. Do you have women return
every 12 months for
CBE an mammography?

Never Sometimes Often Always

5. How often do you refer
patients to a breast
clinic?

Never Sometimes Often Always

Evaluation

1. How often do you offer your
telephone number to avail
yourself for breast health
questions?

Never Sometimes Often Always

2. How often do you make follow-
up phone calls to discuss
breast test findings?

Never Sometimes Often Always

Demographics

1. How many years have you been in practice? _____

2. What is your education level? _____

3. Age: _____

4. Male _____ Female _____

Females Only:

Do you perform monthly BSE? Yes _____ No _____

If you are over age 50, do you have a CBE and mammography every
12 months? Yes _____ No _____

Do you currently have breast cancer? Yes _____ No _____

Have you ever had breast cancer? Yes _____ No _____

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