BREAST QUESTIONNAIRE

NAME: ______________________________ **DOB:** ______________

DOCTOR: ______________________________ **DATE:** ______________

Do you have a personal history of breast cancer? **YES NO**

If yes: What type of treatment? (Circle): Chemotherapy Mastectomy Radiation

Other: ______________________________

Is there a family history of breast cancer? **YES NO**

Relationship to you: ______________

Age menses began: ________

# of pregnancies: ________ # of deliveries: ________ # of miscarriages: ________

Have you ever taken birth control? **YES NO**

If yes: What kind? (Circle): Implant Injection IUD Oral Patch

Other: ______________________________

What age did you begin taking birth control? ________

Amount of time on birth control: ______ years ______ months

Have you ever taken hormone replacement therapy? **YES NO**

Age you began hormone replacement: ________

Estimated time on hormone replacement therapy: ______ years ______ months

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Do you feel a lump in your breast? **YES NO** If yes (Circle): Both Right Left

Do you have nipple discharge? **YES NO** If yes (Circle): Both Right Left

Do you smoke or use tobacco products? **YES NO**

How much? (Circle): > 1 pack per day 1 pack per day < 1 pack per day

How long have you smoked or used tobacco products? ______ years ______ months

Do you drink alcohol? **YES NO** If yes: How much? (Circle): Rarely Moderately Daily

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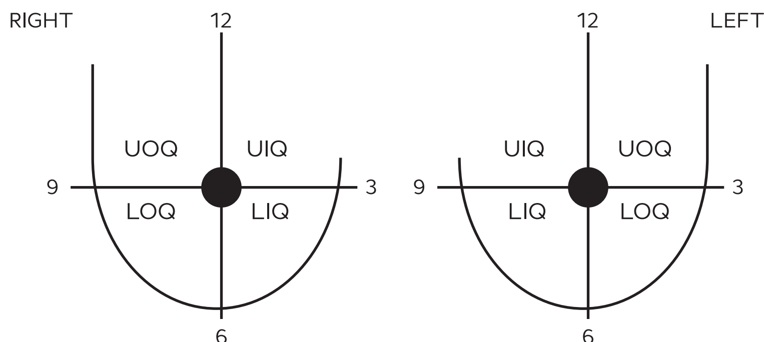

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