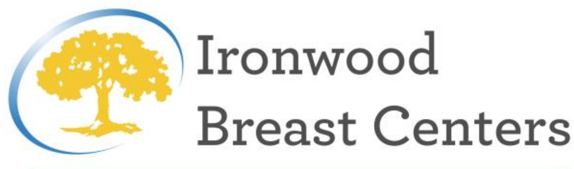
Name: ______________________ DOB: ____________ Acc# ____________




# BREAST QUESTIONNAIRE

What problem brought you here today? ________________________________

Have you ever breast fed? ☐ Yes ☐ No
Are you currently breast feeding? ☐ Yes ☐ No

Do you take anticoagulants? ☐ Yes ☐ No
If yes, please list: ______________________________

Are you currently experiencing any of the following?

| | | | | | | |
|---|---|---|---|---|---|---|
| Abnormal Mammogram | ☐ Yes | ☐ No | Which side: | ☐ Right | ☐ Left | ☐ Both |
| Breast Lump | ☐ Yes | ☐ No | Which side: | ☐ Right | ☐ Left | ☐ Both |
| Lump Under Your Arm | ☐ Yes | ☐ No | Which side: | ☐ Right | ☐ Left | ☐ Both |
| Nipple Discharge | ☐ Yes | ☐ No | Which side: | ☐ Right | ☐ Left | ☐ Both |
| Breast Pain | ☐ Yes | ☐ No | Which side: | ☐ Right | ☐ Left | ☐ Both |

If yes, please rate your pain on a scale of 1-10 (where 10 is the worst): ____________________

In the past, have you had any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Breast Biopsies | ☐ Yes | ☐ No | Year: ________ | Which side: | ☐ Right | ☐ Left | ☐ Both |
| | ☐ Yes | ☐ No | Year: ________ | Which side: | ☐ Right | ☐ Left | ☐ Both |
| | ☐ Yes | ☐ No | Year: ________ | Which side: | ☐ Right | ☐ Left | ☐ Both |

Did a biopsy ever show atypical ductal hyperplasia (ADH): ☐ Yes ☐ No
Did a biopsy ever show lobular carcinoma in-situ (LCIS): ☐ Yes ☐ No

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Breast Cysts Drained: | ☐ Yes | ☐ No | Year: ________ | Which side: | ☐ Right | ☐ Left | ☐ Both |
| Breast Implants | ☐ Yes | ☐ No | Year: ________ | ☐ Silicone | ☐ Saline | ☐ Combination | |
| Breast reduction | ☐ Yes | ☐ No | Year: ________ | | | | |

## Have you ever had?

Breast Cancer ☐ Yes ☐ No

| | | | |
|---|---|---|---|
| If yes, did you have a: | Lumpectomy: | ☐ Yes | ☐ No |
| | Mastectomy: | ☐ Yes | ☐ No |
| | Radiation: | ☐ Yes | ☐ No |
| | Chemotherapy: | ☐ Yes | ☐ No |

## Did you have breast reconstruction? ☐ Yes ☐ No

If yes, what type? ______________
Have you had any other type of cancer? ☐ Yes ☐ No If yes, what type? ______________

| | | | |
|---|---|---|---|
| Did you receive: | Radiation: | ☐ Yes | ☐ No |
| | Chemotherapy: | ☐ Yes | ☐ No |

Does a physician examine your breasts every year? ☐ Yes ☐ No
How often do you examine your breasts? ☐ Monthly ☐ Occasionally ☐ Never

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Are you currently taking or have you ever taken any of the following hormonal medications?

| | | | | |
|---|---|---|---|---|
| Birth Control Pills: | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Estrogen: | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Progesterone: | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Tamoxifen: | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Raloxifene (Evista): | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Arimidex (Anastrazole): | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Letrozole (Femara): | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Exemestane (Aromasin): | ☐ Yes | ☐ No | Duration: | Side Effects: |
| Prempro: | ☐ Yes | ☐ No | Duration: | Side Effects: |

Do you eat or drink foods or beverages containing caffeine? (e.g. coffee, tea, or chocolate) ☐ Yes ☐ No
If yes, list average daily consumption:

Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes 5 times a week or more

Inheritance of certain genes can be important to your risk of breast cancer.
Are you of Ashkenazi Jewish Ancestry? ☐ Yes ☐ No
Are you aware of BRCA 1 / 2 or other gene positivity in your family? ☐ Yes ☐ No

## Family History

Has any blood relative had breast cancer? ☐ Yes ☐ No (If yes, list specific information below)

| Relationship | Maternal | Paternal | Age at diagnosis or approx age | One or both breasts affected | Current status of relative |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Has any blood relative had ovarian cancer? ☐ Yes ☐ No (If yes, list specific information below)

| Relationship | Maternal | Paternal | Age at diagnosis or approx. age | Current status of relative |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Has any blood relative had any other type of cancer? ☐ Yes ☐ No (If yes, list specific information below)
(especially prostate, colon, uterine, pancreatic, gastric, melanoma, sarcoma, brain, lung, thyroid, or leukemia)

| Relationship | Maternal | Paternal | Age at diagnosis or approx. age | Type of Cancer | Current status of relative |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Name: ______________________ DOB: ______________ Acc# ______________
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Has any blood relative had? (if yes, list specific information below)

Osteoporosis: ☐ Yes ☐ No
Strokes: ☐ Yes ☐ No
Heart Attacks: ☐ Yes ☐ No
Thyroid Disease: ☐ Yes ☐ No
Blood Clots: ☐ Yes ☐ No

| Relationship | Maternal | Paternal | Age at diagnosis or approx. age | List Diagnosis | Current status of relative |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |