Breast History Questionnaire

Name: _____ Birthdate: _____ Referring Dr. : _____

Age at first period: _____ Number of pregnancies: _____ Age at first pregnancy:_____

Breast Feeding? _____ BC Pills, if taken, total years: _____

Age at Menopause: _____ Ovaries still in? Yes _____ No _____

Number of previous breast biopsies? _____

Number of first-degree relatives with breast cancer?

_____ Mother _____ Daughter _____ Sister If so, What type? _____

Hormone Replacement Pills? Yes ___ No ___ If yes, What kind? _____

Self-Breast Exams? Yes ___ No ___ If Yes, monthly? _____ Yes _____ No

Problem in breast exam? _____ Yes _____ No

Present History Of Breast Disease:

Did you have a breast surgery? ___Yes ___ No Which Side? _____

Can you feel a breast mass now? ___ Yes ___ No Since When? _____

Do you have pain in the breasts? ___ Yes ___ No Since When? _____

Do you have nipple discharge? ___ Yes ___ No Since When? _____

Do you have nipple retraction? ___ Yes ___ No Since When? _____

Do you have any skin dimples? ___ Yes ___ No Since When? _____

Do you have breast prosthesis? ___ Yes ___ No Since When? _____

Do you have breast cysts? ___ Yes ___ No Since When? _____

Did you have needle aspiration? ___ Yes ___ No Since When? _____

Do you have fibrocystic disease? ___ Yes ___ No Since When? _____

Did you have breast cancer? ___ Yes ___ No Since When? _____

Do you get yearly mammograms? ___ Yes ___ No Since When? _____

Date of last mammogram? _____ Where? _____

Did you have an ultrasound? ___ Yes ___ No If yes, where? _____