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BREAST QUESTIONNAIRE

PATIENT NAME: _____ **SSN #:** _____ **TODAY'S DATE** _____

PREGNANCY:

Age of first pregnancy: _____ Did you breast feed? ☐ Yes ☐ No
Number of living children: _____

MENSTRUAL PERIODS:

Age of your first menstrual period: _____ Are your periods regular? ☐ Yes ☐ No
Date last period began: _____ Age at Menopause? _____
Do you have difficulties with your periods? ☐ Yes ☐ No

FAMILY HISTORY:

Has anyone in your family had breast cancer? ☐ Yes ☐ No
If so, who had breast cancer? _____ At what age did they have breast cancer? _____

Has anyone in your family had ovarian cancer? ☐ Yes ☐ No
If so, who had ovarian cancer? _____ At what age did they have ovarian cancer? _____

BIRTH CONTROL

Have you ever taken birth control pills? ☐ Yes ☐ No When and for how long? _____

HORMONE THERAPY:

Have you ever taken hormones)? ☐ Yes ☐ No What drug? _____
(e.g. Premarin / Prempro) When and for how long? _____

TESTS:

Do you perform self breast exams? ☐ Yes ☐ No
When and where was your last mammogram? _____
When and where was your last pap smear? _____

CURRENT PROBLEM:

Current Problem	Yes	No	When did you first notice?
Lump you can feel	☐	☐	_____
Pain	☐	☐	_____
Nipple Discharge	☐	☐	_____
Breast Trauma	☐	☐	_____
Abnormal Mammogram	☐	☐	_____
Other	☐	☐	_____

I certify that, to the best of my knowledge, the above information is complete and accurate.

Patient's Signature: _____

Today's Date: _____