

BREAST EXAM QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____ DATE: _____

REFERRING PHYSICIAN: _____

REASON FOR TODAY'S VISIT: _____

IS THERE A POSSIBILITY OF PREGNANCY NOW? Y / N

ARE YOU TAKING FEMALE HORMONES OR BIRTH CONTROL PILLS AT THIS TIME? Y / N

IF YES, WHAT KIND? _____

MENSTRUAL HISTORY

AGE OF ONSET _____

LAST PERIOD _____

CHILDBIRTH HISTORY

NUMBER OF PREGNANCIES _____

AGE AT FIRST PREGNANCY _____

HAVE YOU HAD A HYSTERECTOMY? Y / N

DID YOU BREASTFEED? Y / N

HAVE YOU HAD OVARIES REMOVED? Y / N

DATE OF LAST BREAST EXAM BY A PHYSICIAN _____

HAVE YOU HAD A MAMMOGRAM? Y / N

IF YES, WHEN AND WHERE? _____

HAVE YOU EVER BEEN DIAGNOSED WITH BREAST CANCER? Y / N DATE: _____

HAVE YOU EVER HAD BREAST SURGERY? Y / N

L/R BREAST SURGERY DATE: _____

L/R BREAST CYST DATE: _____

L/R BREAST BIOSPY DATE: _____

FAMILY HISTORY: ANY BLOOD RELATIVE HAD BREAST CANCER? Y / N OVARIAN? Y/N

{ } MOTHER

{ } FATHER

{ } SIBLING

{ } GRANDMOTHER: MATERNAL/PATERNAL

{ } DAUGHTER

{ } AUNT: MATERNAL/PATERNAL

{ } COUSIN

{ } NIECE