

# 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 A THIS TIME? Y / N

IF YES, WHAT KIND? \_\_\_\_\_ HOW LONG? \_\_\_\_\_

## CHILDBIRTH HISTORY

NUMBER OF PREGNANCIES \_\_\_\_\_

AGE AT FIRST PREGNANCY \_\_\_\_\_

DID YOU BREAST FEED? Y / N

HAVE YOU HAD A HYSTERECTOMY? Y / N

DATE OF LAST BREAST EXAM BY A PHYSICIAN? \_\_\_\_\_

HAVE YOU HAD A MAMMOGRAM? Y / N

IF YES, WHEN AND WHERE? \_\_\_\_\_

## MENSTRUAL HISTORY

AGE OF ONSET? \_\_\_\_\_

LAST PERIOD? \_\_\_\_\_

HAVE YOU HAD OVARIES REMOVED? Y / N

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

HAVE YOU EVER HAD BREAST SURGERY? Y / N

L/R BREAST SURGERY DATE: \_\_\_\_\_

L/R BREAST CYST DATE: \_\_\_\_\_

L/R BREAST BIOPSY DATE: \_\_\_\_\_

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

IF YES, WHO AND AGE DIAGNOSED?

( ) MOTHER

( ) SIBLING

( ) DAUGHTER

( ) FATHER

( ) GRANDMOTHER MATERNAL/PATERNAL

( ) AUNT MATERNAL/PATERNAL

( ) COUSIN MATERNAL/PATERNAL

( ) NIECE MATERNAL/PATERNAL