

## Breast Patient Health Questionnaire

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Do you have a family history of Breast Cancer?  YES  NO

**If yes,** please list who had breast cancer and the age that they were diagnosed.

<u>Relationship</u>	<u>Age</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have a family history of Ovarian Cancer?  YES  NO

**If yes,** please list who had ovarian cancer and the age that they were diagnosed.

<u>Relationship</u>	<u>Age</u>	<u>Relationship</u>	<u>Age</u>
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been pregnant?  YES  NO

- How many times? \_\_\_\_\_
- Your age at time of first pregnancy? \_\_\_\_\_
- How many children did you carry to full term? \_\_\_\_\_

Did you breast feed?  YES  NO **If yes,** for how long? \_\_\_\_\_

Are you currently on any hormone replacement therapy (HRT) or Birth Control Pills?  
 YES  NO

**If yes,** what type of HRT or Birth Control Pills are you on, and how many years have you been on them?

Type: \_\_\_\_\_ # of years: \_\_\_\_\_

**If no,** have you **ever** been on HRT or Birth Control Pills?

**If yes,** for how long? \_\_\_\_\_

Have you had any previous surgeries on either of your breasts?  
i.e.,: Aspirations, augmentation, biopsies, infections, lifts, reductions, etc.

YES  NO

**If yes,** please list the procedure/s and dates.

<u>Procedure</u>	<u>Date</u>
_____	_____
_____	_____

Are you experiencing any discharge from either of your nipples?  YES  NO

**If yes,** is it bloody?  YES  NO