



Breast Questionnaire

Please complete prior to appointment. These personal questions will be kept confidential between you and your physician. This questionnaire will help you physician with your breast cancer care

Name: _____ **Referring Doctor:** _____

Reason for Consultation: _____

Age: _____

Age at First Menstrual Period: _____

Age at First Pregnancy: _____

of Pregnancies: ____ **# of Live Births:** _____ **# of Abortions/Miscarriages:** _____

Did you Breast Feed: Yes No **Any Previous Breast Problems:** _____

Previous Hysterectomy: Yes No **Ovaries Removed:** Yes No

Any Nipple Discharge: Yes No **Do you do Breast Self Exams:** Yes No

Do you feel any mass now: Yes No **Any Nipple or Breast Skin Problem:** Yes No

Do you have any Heart Disease: Yes No **Do you have any Bone Problems:** Yes No

Any Family History of Breast Disease: Yes No **Who:** _____

Any Family History of Ovarian Cancer: Yes No **Who:** _____

When was your last mammogram: _____ **Where was it done:** _____