

## BREAST HEALTH QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

### **PERSONAL HISTORY: \* Please answer the following\***

Age of first period: \_\_\_\_\_ When was your last period? \_\_\_\_\_  
Age at first full-term pregnancy: \_\_\_\_\_ How many children do you have? \_\_\_\_\_  
Have you ever terminated a pregnancy? \_\_\_\_\_ If so, when? \_\_\_\_\_  
Are you taking any oral contraceptives or estrogen replacement? \_\_\_\_\_  
If so, for how long? \_\_\_\_\_  
Have you ever taken fertility drugs? \_\_\_\_\_ If so, when? \_\_\_\_\_

### ***FAMILY HISTORY: \*Please indicate "yes" and approximate age of diagnosis as appropriate if the following family members have a history of Breast or Ovarian Cancer\****

Mother \_\_\_\_\_ Maternal Grandmother \_\_\_\_\_  
Paternal Grandmother \_\_\_\_\_ Sisters \_\_\_\_\_  
Maternal Aunts \_\_\_\_\_ Paternal Aunts \_\_\_\_\_  
Daughters \_\_\_\_\_ Other \_\_\_\_\_

### ***PERSONAL BREAST HEALTH HISTORY: \*Please indicate dates\****

Last mammogram: \_\_\_\_\_  
Biopsy: L \_\_\_\_\_ R \_\_\_\_\_  
Aspiration: L \_\_\_\_\_ R \_\_\_\_\_  
Mastectomy: L \_\_\_\_\_ R \_\_\_\_\_  
Lumpectomy: L \_\_\_\_\_ R \_\_\_\_\_  
Chemotherapy: No \_\_\_\_\_ Yes \_\_\_\_\_ (dates) \_\_\_\_\_  
Radiation: No \_\_\_\_\_ Yes \_\_\_\_\_ (dates) \_\_\_\_\_  
Implants: No \_\_\_\_\_ Yes \_\_\_\_\_ (dates) \_\_\_\_\_  
Reduction: No \_\_\_\_\_ Yes \_\_\_\_\_ (dates) \_\_\_\_\_

Any history of Breast Cancer, Ovarian Cancer, or Atypia? \_\_\_\_\_