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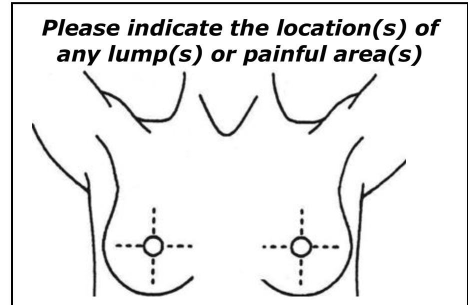
BREAST SCREENING QUESTIONNAIRE

Please indicate any current problems you are having with your breasts and/or nipples. If not applicable, please write "none" or "n/a."



Lump? If yes, which breast(s)? ______________________

Nipple discharge? If yes, which breast(s)? _____________

Pain or soreness? If yes, which breast(s)? _____________

Prior Breast Imaging

Have you had any previous breast imaging? □ Yes □ No

IF NOT HERE, where/when? ___________________________________

1) PERSONAL AND FAMILY CANCER HISTORY

Type of cancer	You, age at diagnosis	Siblings/Children, age(s) at diagnosis	Mother's side, age(s) at diagnosis	Father's side, age(s) at diagnosis
Breast cancer				
Ovarian cancer				
Breast cancer in both breasts OR multiple primary breast cancers				
Male breast cancer				

Are you of Ashkenazi Jewish descent? □ Yes □ No

Have you ever had a BRCA genetic test? □ Yes □ No

If YOU have ever been diagnosed with breast cancer, please answer the following questions.

When were you diagnosed? _______________________

Which breast(s)? _______________________________

Have you taken Tamoxifen? □ Yes □ No

Have you undergone radiation therapy? □ Yes □ No

Have you undergone chemotherapy? □ Yes □ No

CONTINUED on the next page

2) GENERAL INFORMATION

Age menstruation began: __________

Age first full term pregnancy: __________

Number of live births: __________

Are you currently breastfeeding? □ Yes □ No

Age at menopause: __________

Are you pregnant? □ Yes □ No

Last menstrual period: ______________________

3) BREAST SURGICAL HISTORY

Have you ever had any type of breast surgery? □ Yes □ No

IF YES, please mark which type(s) below. If NO, please continue to the next section.

□ Cyst aspiration:

Which breast(s)? ________ When? ________

□ Needle biopsy:

Which breast(s)? ________ When? ________

□ Stereotactic biopsy:

Which breast(s)? ________ When? ________

□ Excisional biopsy:

Which breast(s)? ________ When? ________

□ Lumpectomy:

Which breast(s)? ________ When? ________

□ Mastectomy:

Which breast(s)? ________ When? ________

□ Breast reduction:

Which breast(s)? ________ When? ________

□ Breast implants:

Which breast(s)? ________ When? ________

Silicone or saline? ______________________

□ Implant replacement or removal?

Which breast(s)? ________ When? ________

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4) GENERAL SURGICAL HISTORY

Have you had a hysterectomy? □ Yes □ No

If yes, when? __________________________

Have you had one or both of your ovaries removed? □ Yes □ No

If yes, when? __________________________

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5) HORMONE THERAPY

Do you currently take or have you ever taken any type of hormone replacement (including estrogen, progesterone, and oral contraceptives)? □ Yes □ No

If yes, when? ____

Which hormone(s)? ____

I attest that the above answers are true and correct to the best of my knowledge.

Signature: ____ **Date:** ______________________

Printed name: ____