

Breast History Questionnaire

Name: _____ Age: _____

Date of Birth: _____ Daytime Phone #: _____

Reason for exam, please circle: Screening Follow up Lump Pain

Please give details for your symptoms (Which side/ duration of pain or lump/ can you feel the lump):

Have you ever had a mammogram? NO YES If yes, where: _____ Date: _____

Number of pregnancies: _____ Number of deliveries: _____ Your age at first full term pregnancy: _____

Still having menstrual periods? NO YES If yes, date of last period: _____ Age of first period: _____

Age of menopause: _____ Are you on hormone replacement therapy? NO YES If yes, how long: _____

Age of hysterectomy/oophorectomy: _____

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|-------------------------------|----|-----|--------------------------------|
| • Breast Reduction | NO | YES | Date of surgery: _____ |
| • Breast Implants | NO | YES | Date of Implants: _____ |
| • Breast Biopsy | NO | YES | If yes, What side: Date: _____ |
| • Breast Cancer | NO | YES | Date of Diagnosis: _____ |
| • Lumpectomy (For cancer) | NO | YES | If yes, What side: Date: _____ |
| • Mastectomy | NO | YES | If yes, What side: Date: _____ |
| • Breast Radiation treatments | NO | YES | Date of last treatment: _____ |
| • Breast Chemotherapy | NO | YES | Date of last treatment: _____ |
| • ANY other type of cancer | NO | YES | If yes, What type: Date: _____ |

Any of the following family members been diagnosed with BREAST Cancer?

- Mother NO YES If yes, age diagnosed: _____
- Sister NO YES If yes, age diagnosed: _____
- Daughter NO YES If yes, age diagnosed: _____

- **Has any other blood relatives diagnosed with breast cancer?**

- **Has any other blood relatives diagnosed with OTHER TYPE of cancer?**

We regret any discomfort you may experience as a result of the breast compression required for your mammogram. The compression improves the images obtained and reduces the amount of radiation exposure. Though a mammogram does help to detect breast cancer, approximately 10-15% of breast cancers are not detected by mammograms, therefore it is important for you to do regular breast self-examinations and see your doctor for physical exams. A report of this exam will be sent to your physician. You will follow up with your physician. You will receive a summary letter from our facility.

Patient Signature: _____ Date: _____