

Patient Name: _____ DOB: _____

Breast Patient Questionnaire

Breast:

LSG004

Do you have a lump you can feel? ____ Yes ____ No

Where? _____

Have you ever had any nipple discharge in the past year? ____ Yes ____ No

If yes, describe color, quantity, frequency and relationship to your periods:

Did you breast feed? ____ Yes ____ No

Do you practice self-breast exam? ____ Yes ____ No How often? _____

Most recent breast exam: _____

When was your first mammogram? _____

Date of the most recent mammogram?(mm/dd/yy) _____

Menstruation:

Age when first menstrual period began: _____

Do you still get your menses (periods)? ____ Yes ____ No

If no, your age at menopause: _____

Date of your last menstrual period: _____

Most recent pelvis exam: _____

How many children do you have? _____

Your age when your first child was born: _____

Have you ever taken contraceptives? ____ Yes ____ No If yes, how long? _____

Name of contraceptive: _____

Have you had a hysterectomy? ____ Yes ____ No Type: vaginal or abdominal (circle)

If yes, when: _____

Were your ovaries removed? ____ Yes ____ No

Have you ever had hormonal (i.e. estrogen or progesterone) therapy? ____ Yes ____ No

If yes, what: _____

Describe:

Describe any symptoms associated with your breasts or menses:

Please describe any relatives who have had breast cancer: (Relationship to you, age at time of diagnosis, present status, if deceased at what age?) _____

Describe any previous breast surgery or studies you have had: (Did you bring the original films/reports with you?) _____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Medical Assistant Initials: _____