Breast Questionnaire

Name: _____ Phone Number: _____

Date of Birth: _____ Physician: _____

This is a screening tool used to identify common features associated with increased cancer risks. Please check any boxes below that apply to **YOU and/or CLOSE FAMILY MEMBERS** (**extend family members out to 1st cousins**). Please fill out this form to the best of your knowledge. If you are uncertain as to your family history, it may be useful to call family members that can help you. The accuracy of the information you provide us below may help us reduce any new or second primary cancers in you. If you do not know the answer to any of the questions listed below, you may leave the box blank.

☐ Yes ☐ No Have you or any close family member been diagnosed with breast cancer at or before the age of 50?

☐ Yes ☐ No If you have a personal history of breast cancer before 60 years old, were you told it was a triple negative breast cancer?

☐ Yes ☐ No Have you been diagnosed with more than 1 breast cancer with the first diagnosis occurring at or before the age of 50?

☐ Yes ☐ No Have you or any close family member been diagnosed with ovarian or male breast cancer?

☐ Yes ☐ No Have 2 or more family members been diagnosed with any of the following cancers: breast, ovarian, pancreatic, or prostate cancer?

☐ Yes ☐ No Are you of Jewish heritage with breast cancer?

☐ Yes ☐ No Has anyone in your family been diagnosed with a hereditary cancer syndrome?

If you checked any of the boxes above, please specify the **type of cancer** including **estimated age at diagnosis** in the appropriate boxes below.

Self:	Children:	Brothers and Sisters:

Mother's (Maternal) Side

Mother: _____

Grandparents: _____

Aunts/Uncles: _____

Nieces/Nephews: _____

Cousins/others: _____

Father's (Paternal) Side

Father: _____

Grandparents: _____

Aunts/Uncles: _____

Nieces/Nephews: _____

Cousins/others: _____

Patient's Signature: _____ Date: _____
Name: _____ Date of Birth: _____

1. Age at menarche (onset of periods): _____

2. Age at first pregnancy: _____

   Number of pregnancies: _____ Number of full term pregnancies: _____

3. Birth control pills? ☐ Current ☐ Past How Long? _____

4. Use of hormones? ☐ Current ☐ Past How Long? _____

5. Date of onset of last menstrual period _____

6. Age of menopause: _____ ☐ Natural ☐ Surgical

7. Amount of caffeine intake per day: _____

8. History of breast surgery? ☐ Yes ☐ No

   If yes, please explain: _____

9. History of breast biopsies? ☐ Yes ☐ No

   Date: _____ Doctor: _____

   Date: _____ Doctor: _____

10. Indicate on the drawing below any scars on breast

11. Do you feel lumps in your breasts? ☐ Yes ☐ No
    If yes, indicate where on the drawing below

12. Nipple discharge? ☐ Yes ☐ No Color _____

    Spontaneous? ☐ Yes ☐ No

    ☐ Right Breast or ☐ Left Breast

13. History of radiation to your chest? ☐ Yes ☐ No

    Explain: _____