EASTSIDE SURGICAL ASSOCIATES

BREAST DISEASE QUESTIONNAIRE

NAME:_____ AGE:_____ TODAY'S DATE:_____

WHICH BREAST IS THE PROBLEM? RIGHT LEFT BOTH

NATURE OF THE PROBLEM (PLEASE CIRCLE) LUMP PAIN NIPPLE DISCHARGE REDNESS

SIZE INCREASE ABNORMAL MAMMOGRAM OTHER

WHO FOUND THE PROBLEM? I MY DOCTOR DATE FOUND:_____

HAVE YOU EVER HAD BREAST SURGERY? YES / NO IF YES, DATE:_____

TYPE OF SURGERY:_____

YOUR AGE WHEN YOU **FIRST** MENSTRUATED _____ YEARS

YOUR AGE WHEN YOU HAD YOUR **FIRST** CHILD _____ YEARS

DO / DID YOU USE BIRTH CONTROL PILLS YES / NO IF YES, HOW LONG:_____

DATE YOU STARTED YOUR **LAST** MENSTRUAL PERIOD _____

IF YOU REACHED MENOPAUSE, YEAR OF MENOPAUSE _____

HAS YOUR UTERUS BEEN REMOVED? YES / NO IF YES, DATE:_____

HAVE YOU HAD ENDOMETRIAL ABLATION? YES / NO IF YES, DATE:_____

HAVE YOUR OVARIES BEEN REMOVED? YES / NO IF YES, ONE/BOTH DATE: _____

ARE YOU TAKING HORMONES? YES / NO IF YES, SINCE WHEN:_____

NAME OF HORMONE:_____

HAVE YOU HAD MAMMOGRAMS? YES / NO IF YES, DATE:_____

PLACE:_____

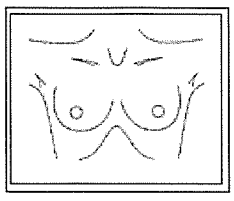
DO YOU HAVE **BLOOD RELATIVES** WITH **BREAST CANCER**? YES / NO IF YES, SPECIFY:_____

_____

ABOVE RELATIVE'S AGE WHEN SHE DEVELOPED BREAST CANCER _____ YEARS

LIST ANY OTHER CANCERS AMONG **BLOOD RELATIVES** _____

_____

DO YOU PERFORM BREST SELF EXAMS? REGULARLY / IRREGULARLY / NO/ I WOULD LIKE TO LEARN

IN THE ADJOINING SKETCH, MARK THE LOCATION OF THE PROBLEM