ValleyHealth
Warren
Surgical Associates

Breast Examination Questionnaire

Your Name: _____ Age: _____

Referring Physician: _____

Breast History:

Have you had any previous breast surgery (e.g. biopsy, mastectomy)? _____

If yes, what type of surgery and when? _____

If yes, was there a diagnosis of breast cancer or pre-cancer? _____

What is your current breast problem? _____

Mammograms:

Date of last mammogram: _____

Examinations:

Do you perform regular self exams? _____ How often? _____

How long ago did a physician perform a breast exam? _____

Obstetric/Gynecologic History:

Number of pregnancies: _____ Your age at first pregnancy: _____

Your age at which menstrual periods began: _____

Is there any history of birth control pill usage? _____ If yes, when? _____

If you have or are using hormones, when (or how long) did you use them? _____

Do you have regular menstrual cycles? _____

Where are you in the present cycle? _____

If you have been through menopause, when did this occur? _____

Have you had a hysterectomy? _____ If yes, when _____ Was the ovaries removed? _____

Other History:

Any medical illnesses? _____

If yes, please list: _____

_____

Habits:

Do you smoke? _____ If yes, how many packs per day? _____

Do you drink coffee? _____ If so, how many cups per day? _____

Do you drink alcohol? _____

Family History:

Is there any history of breast cancer in blood relatives? _____

If yes, then which relatives? _____

and, if you know, what was the age at diagnosis? _____

was the breast cancer on both sides? _____

Is there nay other family history of cancer? _____

If yes, what type(s)? _____