



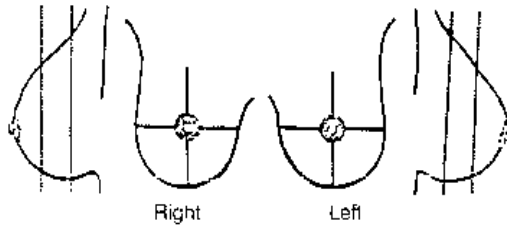
BREAST QUESTIONNAIRE

PATIENT NAME: _____ DOB: _____

ACCOUNT / SS #: _____ Referring Physician: _____

YES **NO**

- 1. Are you pregnant?
- 2. Do you have a family history of breast cancer? Age at Diagnosis: _____
(Self, Mother, Sister, Grandmother, Aunt, or Daughter)
- 3. Have you had a mammogram before?
If yes, where: _____
Approximate date: _____
- 4. Are you or your doctor feeling any lumps in your breasts now?
If yes, please diagram the location on the drawing.



- 5. Are you having any of the following symptoms?

Left	Right	
<input type="checkbox"/>	<input type="checkbox"/>	Palpable lump or thickening
<input type="checkbox"/>	<input type="checkbox"/>	Bloody discharge
<input type="checkbox"/>	<input type="checkbox"/>	Non-bloody discharge
<input type="checkbox"/>	<input type="checkbox"/>	Skin thickening or dimpling
<input type="checkbox"/>	<input type="checkbox"/>	Nipple abnormality
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

- 6. Previous Breast Procedures? Left Right Date

a. Cyst aspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
b. Biopsy, needle	<input type="checkbox"/>	<input type="checkbox"/>	_____
c. Biopsy, surgical	<input type="checkbox"/>	<input type="checkbox"/>	_____
d. Lumpectomy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
e. Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
f. Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____
g. Implants	<input type="checkbox"/>	<input type="checkbox"/>	_____
h. Silicone injections	<input type="checkbox"/>	<input type="checkbox"/>	_____
i. Breast reduction	<input type="checkbox"/>	<input type="checkbox"/>	_____
j. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

- 7. Are you currently taking Hormones?
(birth control pills, Estrogen, or Progestin)
If yes, which ones? _____ Number of years? _____

Patient Signature: _____ Date: _____

Baptist M&S Staff FULL Signature: _____ Date: _____