

BREAST HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____
Address: _____ Phone: Hm: _____
_____ Cell/Work: _____
G.P: _____ e-mail: _____

preferred
method of
contact:

General History:

Nationality: _____ Occupation: _____
Weight: _____ Height: _____ Age: _____

Office
use only

Menstrual History:

Age of onset: _____ Period length (days): _____ Length of monthly cycle: _____
Day of cycle today (day of appointment): _____ (Day 1 being the first day of bleeding)
Are you menopausal? Yes / No Age of onset? _____ Date of last period? _____
Hysterectomy: Yes / No Age: _____ Ovaries removed: Yes / No

Drugs:

Have you ever taken Oral Contraceptives/Mirena/Depo? Yes / No Age started: _____ Years taken: _____
Have you ever taken Synthetic Hormone Replacement Therapy? Yes / No I.V.F? Yes/No
If yes, please specify: _____ Years taken: _____
Have you ever taken Natural Hormone Replacement Therapy? Yes / No
If yes, please specify: _____ Years taken: _____
Are you taking any medication now? Please specify: _____
Are you taking any supplements now? Please specify: _____

Pregnancies:

Age at 1st pregnancy: _____ Was first pregnancy to full term? Yes / No Are you pregnant now? Yes / No
Number of children breastfed 6 months or longer: _____ Breastfeeding now? Yes / No

Family History of Breast Cancer

Self _____ Maternal relatives: _____
Mother _____ Paternal relatives: _____
Sister _____
Daughter _____

