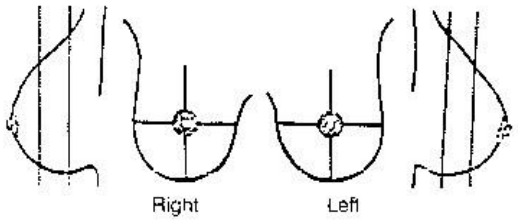
BREAST QUESTIONNAIRE

Patient Name: _____ DOB: _____

Referring Physician: _____ Date of next physician visit: _____

Last 4 numbers of SS#: _____

YES	NO	
☐	☐	1. Are you pregnant?
☐	☐	2. Do you have a family history of breast cancer? Age at Diagnosis: _____ (Mother, Sister, Grandmother, Aunt, or Daughter)
☐	☐	3. Do you have a personal history of breast Cancer? Age at Diagnosis: _____
☐	☐	4. Have you had a mammogram before? **If yes, where:** _____ **Approximate date:** _____
☐	☐	5. Are you or your doctor feeling any lumps in your breasts now? If yes, please diagram the location on the drawing.



☐	☐	6. Are you having any of the following symptoms?		
Left	Right			
☐	☐	Palpable lump or thickening		
☐	☐	Bloody discharge		
☐	☐	Non-bloody discharge		
☐	☐	Skin thickening or dimpling		
☐	☐	Nipple abnormality		
☐	☐	Pain		
☐	☐	Other: _____		
☐	☐	7. Previous Breast Procedures?	Left	Right / Date
		a. Cyst aspiration	☐	☐ _____
		b. Biopsy, needle	☐	☐ _____
		c. Biopsy, surgical	☐	☐ _____
		d. Lumpectomy for cancer	☐	☐ _____
		e. Mastectomy	☐	☐ _____
		f. Radiation treatment	☐	☐ _____
		g. Implants	☐	☐ _____
		h. Silicone injections	☐	☐ _____
		i. Breast reduction	☐	☐ _____
		j. Other: _____	☐	☐ _____
☐	☐	8. 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: _____

MS 465 Rev. 12/15

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