BREAST HEALTH QUESTIONNAIRE

Official use only

LAST NAME___________________FIRST NAME__________________ DOB______AGE______ ( )AGE
ADDRESS____
PH NO_______________OCCUPATION_____________________G.P._______________________

DRUGS

ORAL CONTRACEPTIVES

Have you ever taken Oral Contraceptive Pills: Yes No Age Started_______ Years taken___ ( )OC
Are you currently taking OC Pills: Yes No

MENOPAUSAL Yes No Age of onset_________ ( )MEN

SYNTHETIC HORMONE REPLACEMENT THERAPY

Have you ever taken SHRT: Yes/No If Yes name of SHRT:________________ Years taken___ ( )HRT

NATURAL HORMONE REPLACEMENT THERAPY

Have you ever taken NHRT: Yes/No If Yes name of NHRT:________________ Years taken___

MEDICATION: (i.e. blood pressure medication etc)____

SUPPLEMENTS:____

MENSTRUAL HISTORY **(on day of appt)**

Length of period:_______Total days in cycle_______Age of onset________***Day of cycle:**_________
Hysterectomy: Yes/No Age______ Ovaries removed: Yes/No ( )HYS

PREGNANCIES

No. of Pregnancies:______Age at 1st Pregnancy_______No. of children nursed more than 1 mth_____ ( )PRE
Pregnant now: Yes No Breastfeeding now: Yes No

FAMILY HISTORY OF BREAST CANCER

Self_____________ Maternal grandmother______________
Mother__________ Aunt_________Cousin_____________
Sister___________ (15) Paternal grandmother_______________ (10) ( )F/H
Daughter________ Aunt_________Cousin______________

PHYSICAL EXAM

Mark affected area with appropriate symbol

Symbols to use:

Biopsy: ↔
Mass: ●
Pain: p
Prominent vein: ≈
Thickening: ○

R L

Other:____

GENERAL HISTORY

NATIONALITY:________________________________WEIGHT:______________ ( )BIO
Have you ever had a biopsy: Yes No How many_________
Needle biopsy_______Surgical biopsy________L______R________Year________
Were you told it was: Benign_______Suspicious_______Malignant_________
Have you ever had:
Lumpectomy: Yes No R L Year _________
Mastectomy: Yes No R L Year _________
Radiation to breast: Yes No R L Month:_______Year________
Have you experienced any blunt trauma to the chest: Yes No Year___________
Do you consistantly use anti-perspirants?____________
Date last: Thermography___________Mammography ___________Breast ultrasound________
Normal / Abnormal Normal / Abnormal Normal / Abnormal
Client temperature____ Room temperature_____________ Amalgams __ Root Canals__ Crowns__

Signed:_______________________________________ Technician signature:______________
Date:____ Date:____________________________

*** Calculate days from 1st day of bleeding to day of appt.** **Total** ( )