

BREAST HEALTH QUESTIONNAIRE

FIRST NAME _____ LAST NAME _____ DATE OF BIRTH ___/___/19__ Age __

ADDRESS _____ CITY _____ ST _____ ZIP _____

Phone Number _____ Fax Number _____

MEDICATIONS Have you ever taken BC pills: Yes ___ No ___ Age started ___ Years taken _____

Are you currently taking Birth Control Pills: Yes ___ No ___ Age started ___ Years taken _____

Birth Control pills taken before 1st pregnancy: Yes ___ No ___

Estrogen Yes ___ No ___ Name of Estrogen taken _____ Years taken _____

Progesterone Yes ___ No ___ Age started ___ Years taken _____ Currently taking Yes ___ No ___

Name (type) of Progesterone: Prescriptive ___ Natural ___ Oral ___ Cream _____

Other drugs: List (i.e. blood pressure medication, etc.) _____

List supplements _____

RELEVANT HISTORY

GENERAL INFORMATION TO CALCULATE RISK INDEX

Menstrual day no. _____ Total days in cycle _____ Age Started _____

Menopause age started: _____ Hysterectomy: Yes ___ No ___ Age _____ Ovaries removed: Age _____ Ovary R ___ L ___

No. of Pregnancies _____ Age at 1st Preg. _____ No. of Live Births _____ No. of children nursed more than 1 mo. _____

Are you Caucasian ___ African American ___ Asian American ___ Native American ___ Jewish ___ Other _____

LBS Overweight : 1 -20 lbs ___ 20– 40 lbs ___ 40 - 60 lbs ___ 60 + lbs ___

Have you experienced ANY blunt trauma to the chest: Yes ___ No ___ Year _____

Do you consistently use anti-perspirants ? _____

FAMILY HISTORY OF BREAST CANCER

Self ___ age ___ Mother ___ Sister ___ Daughter _____

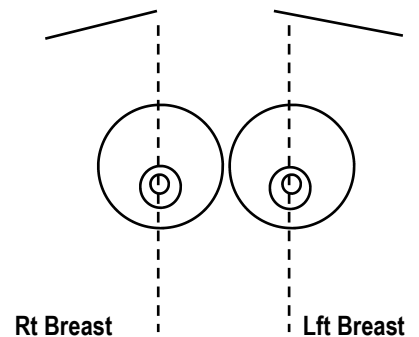
Maternal grandmother _____ Maternal aunt _____ Maternal cousin _____

Paternal grandmother _____, Paternal aunt _____, Paternal cousin _____

NOTES

Physical Exam: Note by letter on the diagram the region of the breasts if affected by any of the following:

- | | | |
|------------------------|----------------------|-----------------------|
| A Mass | B Thickening | C Discharge |
| D Nipple Change | E Skin change | F Area of pain |
| G Burning | H Tender | I Dull ache |
| J Sharp pain | K Implants | |



Have you ever had a biopsy: Yes ___ No ___ How many _____

Needle biopsy ___ Surgical biopsy ___ L ___ R ___ Position _____ Year _____

Were you told it was: Benign ___ Suspicious ___ Malignant _____

Lumpectomy : Yes ___ No ___ R _____ L _____ Year of surgery _____

Mastectomy: Yes ___ No ___ R _____ L _____ Year of surgery _____

Radiation to breast: Yes ___ No ___ R _____ L _____ Month: _____ Year: _____

Chemotherapy: Yes ___ No ___ Month: _____ Year: _____

Date of last thermal image _____ Date of last mammography exam _____ Date of last breast ultrasound _____
Normal ___ Abnormal ___ Normal ___ Abnormal ___ Normal ___ Abnormal ___

Room Temperature _____ Client Temperature _____

The information supplied is, to my knowledge, true and complete.

Patient's Name : _____

Signed : _____

Date : _____

Technician Initial _____

Date: _____