BREAST QUESTIONNAIRE

PLEASE FILL OUT THE TOP PORTION PRIOR TO YOUR FIRST VISIT

Name: _____ Referring Doctor: _____

Reason for consultation: _____

_____

_____

Age:	Age at first menstrual period:	Age of first pregnancy:
Number of pregnancies:	Number of live births:	Number of abortions, miscarriage:

Did you breast feed?	Yes	No	Any previous problems?	Yes	No
Previous hysterectomy?	Yes	No	Ovaries removed?	Yes	No
Any nipple discharge?	Yes	No	Do you do breast self exams?	Yes	No
Any mass you feel?	Yes	No	Any nipple or breast skin problems?	Yes	No
Do you have any heart disease?	Yes	No	Any bone problems?	Yes	No

Family history of breast disease?	Yes	No	Who?
Family history of ovarian cancer?	Yes	No	Who?

PHYSICIAN EVALUATION

Gail model risk assessment score: _____ Tamoxifen discussion: _____min

Exam:

Mammogram reviewed:

Past medical history:

Impression/plan: