



PATIENT QUESTIONNAIRE FOR BREAST CONDITIONS

DuPage Surgical Consultants, Ltd.

Name: _____
Age: _____

Date: _____
Date of birth: _____

Date of last menstrual period _____
Number of pregnancies _____
Number of births _____
Age of menopause (if applicable) _____

Age of first menstrual period _____
Age at first birth _____
Breastfeeding Y / N How long? _____

Have you ever received hormonal therapy?

Birth control pills	Y / N	If yes, for how long?	_____	At present time?	Y / N
Estrogen	Y / N	If yes, for how long?	_____	At present time?	Y / N
Progesterone	Y / N	If yes, for how long?	_____	At present time?	Y / N
Fertility treatment	Y / N	If yes, for how long?	_____	At present time?	Y / N

Please indicate if any of the following apply to you:

	<u>Right Breast</u>	<u>Left Breast</u>	<u>Comments</u>
Breast tenderness	Y / N	Y / N	_____
Breast lumps	Y / N	Y / N	_____
Breast cysts	Y / N	Y / N	_____
Breast cyst aspirations	Y / N	Y / N	_____
Changes in breast size	Y / N	Y / N	_____
Injury to the breast	Y / N	Y / N	_____
Abnormal mammogram	Y / N	Y / N	_____
Previous breast biopsy	Y / N	Y / N	_____
Previous breast surgery	Y / N	Y / N	_____

Do you have a family history of breast cancer?

<u>Maternal Side</u>		<u>Comments</u>	<u>Paternal Side</u>		<u>Comments</u>
mother	Y / N	_____			
sister	Y / N	_____			
grandmother	Y / N	_____	grandmother	Y / N	_____
great-grandmother	Y / N	_____	great-grandmother	Y / N	_____
aunt	Y / N	_____	aunt	Y / N	_____
cousin	Y / N	_____	cousin	Y / N	_____
other	Y / N	_____	other	Y / N	_____

Comments _____

_____ M.D.