Name: _____ DOB: _____ Acc# _____

Ironwood Women's Centers
Ironwood Cancer & Research Centers

BREAST QUESTIONNAIRE

What problem brought you here today? _____

Are you currently experiencing any of the following?

Abnormal Mammogram	☐ Yes	☐ No	Which side:	☐ Right	☐ Left	☐ Both
Breast Lump	☐ Yes	☐ No	Which side:	☐ Right	☐ Left	☐ Both
Lump Under Your Arm	☐ Yes	☐ No	Which side:	☐ Right	☐ Left	☐ Both
Nipple Discharge	☐ Yes	☐ No	Which side:	☐ Right	☐ Left	☐ Both
Breast Pain	☐ Yes	☐ No	Which side:	☐ Right	☐ Left	☐ Both

If yes, please rate your pain on a scale of 1-10 (where 10 is the worst): _____

In the past, have you had any of the following?

Breast Biopsies	☐ Yes	☐ No	Year: _____	Which side:	☐ Right	☐ Left	☐ Both
	☐ Yes	☐ No	Year: _____	Which side:	☐ Right	☐ Left	☐ Both
	☐ Yes	☐ No	Year: _____	Which side:	☐ Right	☐ Left	☐ Both

Did a biopsy ever show atypical ductal hyperplasia (ADH): ☐ Yes ☐ No
Did a biopsy ever show lobular carcinoma in-situ (LCIS): ☐ Yes ☐ No

Breast Cysts Drained:	☐ Yes	☐ No	Year: _____	Which side:	☐ Right	☐ Left	☐ Both
Breast Implants	☐ Yes	☐ No	Year: _____	☐ Silicone	☐ Saline	☐ Combination	
Breast reduction	☐ Yes	☐ No	Year: _____				

Have you ever had?
Breast Cancer ☐ Yes ☐ No
If yes, did you have a:

Lumpectomy:	☐ Yes	☐ No
Mastectomy:	☐ Yes	☐ No
Radiation:	☐ Yes	☐ No
Chemotherapy:	☐ Yes	☐ No

Did you have breast reconstruction? ☐ Yes ☐ No
If yes, what type?
Have you had any other type of cancer? ☐ Yes ☐ No If yes, what type?
Did you receive: Radiation: ☐ Yes ☐ No
Chemotherapy: ☐ Yes ☐ No

Does a physician examine your breasts every year? ☐ Yes ☐ No
How often do you examine your breasts? ☐ Monthly ☐ Occasionally ☐ Never

Are you currently taking or have you ever taken any of the following hormonal medications?

Birth Control Pills:	☐ Yes	☐ No	Duration:	Side Effects:
Estrogen:	☐ Yes	☐ No	Duration:	Side Effects:
Progesterone:	☐ Yes	☐ No	Duration:	Side Effects:

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Tamoxifen:	☐ Yes	☐ No	Duration:	Side Effects:
Raloxifene (Evista):	☐ Yes	☐ No	Duration:	Side Effects:
Arimidex (Anastrazole):	☐ Yes	☐ No	Duration:	Side Effects:
Letrozole (Femara):	☐ Yes	☐ No	Duration:	Side Effects:
Exemestane (Aromasin):	☐ Yes	☐ No	Duration:	Side Effects:
Prempro:	☐ Yes	☐ No	Duration:	Side Effects:

Do you eat or drink foods or beverages containing caffeine? (e.g. coffee, tea, or chocolate) ☐ Yes ☐ No
If yes, list average daily consumption:

Do you exercise? ☐ Never ☐ Sometimes ☐ 30 minutes 5 times a week or more

Inheritance of certain genes can be important to your risk of breast cancer.
Are you of Ashkenazi Jewish Ancestry? ☐ Yes ☐ No
Are you aware of BRCA 1 / 2 or other gene positivity in your family? ☐ Yes ☐ No

Family History

Has any blood relative had breast cancer? ☐ Yes ☐ No (If yes, list specific information below)

Relationship	Maternal	Paternal	Age at diagnosis or approx age	One or both breasts affected	Current status of relative

Has any blood relative had ovarian cancer? ☐ Yes ☐ No (If yes, list specific information below)

Relationship	Maternal	Paternal	Age at diagnosis or approx. age	Current status of relative

Has any blood relative had any other type of cancer? ☐ Yes ☐ No (If yes, list specific information below)
(especially prostate, colon, uterine, pancreatic, gastric, melanoma, sarcoma, brain, lung, thyroid, or leukemia)

Relationship	Maternal	Paternal	Age at diagnosis or approx. age	Type of Cancer	Current status of relative

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Has any blood relative had? (if yes, list specific information below)

Osteoporosis:	☐ Yes	☐ No
Strokes:	☐ Yes	☐ No
Heart Attacks:	☐ Yes	☐ No
Thyroid Disease:	☐ Yes	☐ No
Blood Clots:	☐ Yes	☐ No

Relationship	Maternal	Paternal	Age at diagnosis or approx. age	List Diagnosis	Current status of relative