BREAST MEDICAL HISTORY QUESTIONNAIRE

Today's Date: _____

Name:_____ Date of Birth: _____

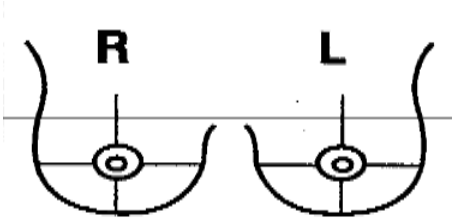
Date of last mammogram: _____ Performed at : _____

Have you had any mammograms prior to this year? [ ] Yes [ ] No Date: _____

Have you been instructed on Self Breast Exam techniques? [ ] Yes [ ] No

Do you examine your breasts on a regular basis? [ ] Yes [ ] No

Do you feel any lumps? [ ] Yes [ ] No If so, please indicate where on this picture.



Please indicate if you have any of the following symptoms :

[ ] Breast pain [ ] Breast tenderness [ ] Nipple Discharge [ ] Skin Changes

Last menstrual period _____ Age at first period _____

Age of menopause _____ Age at first childbirth _____

Number of pregnancies _____ Number of children _____

Number of daughters _____ Number of sisters _____

Have you had previous breast surgery? [ ] Yes [ ] No

If yes, what kind of surgery and why: _____

Has anyone in your family had breast cancer? [ ] Yes [ ] No

Please indicate their relationship and age at onset of the cancer:

[ ] Yourself (age _____) [ ] Mother (age_____)

[ ] Sister (age _____) [ ] Maternal Grandmother (age _____)

[ ] Maternal Aunt (age _____) [ ] Paternal Grandmother (age _____)

[ ] Paternal Aunt (age _____) [ ] Cousin (age _____)

Has anyone in your family had ovarian cancer? [ ] Yes [ ] No

If yes, who and at what age? _____

Have you ever taken estrogen or hormones? [ ] Yes [ ] No

If yes, when did you take them and for how long? _____

Are you currently taking birth control pills? [ ] Yes [ ] No

Are you of Ashkenazi Jewish descent? [ ] Yes [ ] No