

BREAST HEALTH QUESTIONNAIRE

TABLE 4

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH ___/___/19___ Age ___
 ADDRESS _____ CITY _____ ST _____ ZIP _____

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 ? _____

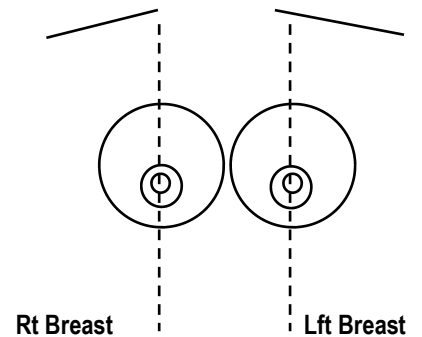
FAMILY HISTORY OF BREAST CANCER

Self ___ age ___ Mother ___ Sister ___ Daughter ___ Maternal grandmother ___
 Maternal aunt ___ Maternal cousin ___
 Paternal grandmother ____, Paternal aunt ____, Paternal cousin ___
 Father _____ Other male members _____

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 | | |



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 ___
 Have you ever had:
 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: ___

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

Client Temperature _____ **Room Temperature** _____

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

Patient's Name : _____
 Signed : _____
 Date : _____

Technician Initial _____
 Date: _____