

# General Surgical Associates, P.C.

## Breast Questionnaire

Date: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_, First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Physician: \_\_\_\_\_

**PLEASE ANSWER ALL THE FOLLOWING QUESTIONS COMPLETELY**

1. Have you or your physician identified a mass in your breast? Yes    No  
 If yes, how long has it been present: \_\_\_\_\_?  
 Is there pain associated with the mass? Yes    No  
 Does the mass change during your menstrual period? Yes    No  
 If yes, how does it change? \_\_\_\_\_
  
2. Have you noticed any change in the shape of your breast? Yes    No
3. Have you experienced any discharge or drainage from your nipple? Yes    No
4. Have you noticed any other lumps or masses? Yes    No  
 If yes, where \_\_\_\_\_  
 How long has it been there? \_\_\_\_\_
5. Have you had X-ray's done of the breast? Yes    No  
 If yes, what type?    Ultrasound    Mammogram    CT    Other, \_\_\_\_\_  
 Where was the X-ray done? \_\_\_\_\_
6. Have you ever had a cyst in either breast? Yes    No  
 If yes, did you have an aspiration? Yes    No  
 If yes, where was the aspiration done? \_\_\_\_\_ And when? \_\_\_\_\_
7. Have you ever been diagnosed with Fibrocystic Breast Disease? Yes    No
8. At what age did you begin your menstrual cycle / period? \_\_\_\_\_
9. What was the date of your last menstrual cycle / period? \_\_\_\_\_
10. What was the age of your first pregnancy? \_\_\_\_\_
11. How many full term pregnancies have you had? \_\_\_\_\_
12. Have you ever breast fed a child in the past? Yes    No  
 If yes, how long? \_\_\_\_\_
13. Have you ever taken Birth Control Pills? Yes    No  
 If yes, how long? \_\_\_\_\_
14. Have you begun menopause? Yes    No  
 If yes, at what age? \_\_\_\_\_
15. Have you ever taken Hormone Replacement medication or therapy? Yes    No  
 If yes, how long? \_\_\_\_\_
16. Do you have a family history of Breast Cancer? Yes    No  
 If yes, who? \_\_\_\_\_  
 What was their age at the time of diagnosis? \_\_\_\_\_
17. Have you ever had trauma or injury to the breast? Yes    No
18. Have you ever had ANY type of radiation therapy to the chest? Yes    No  
 If yes, when? \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_