

15. Have you ever been diagnosed with OVARIAN CANCER?

- Yes, under age 45
- Yes, between ages 45-49
- Yes, between ages 50-54
- Yes, over age 55
- No

16. Have you ever been treated with radiation therapy (more than one radiation dose) to the neck or chest for Hodgkin's disease?

- Yes, before age 20
- Yes, at age 20 or older
- No

17. What is your current height?

feet  inches

18. What is your current weight?

pounds

19. How many years of school have you completed?

- 0 to 11 years
- High school graduate or GED
- Some college or technical school
- College Graduate
- Some graduate school or advanced degree

20. Are you of Hispanic, Spanish or Latino origin?

- Yes
- No

21. What is your racial background? (Fill in all that apply)

- White or Caucasian
- Black or African-American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native
- Other:

All information will be kept confidential as provided by law. If you DO NOT wish to have this information used for research, please fill in here:

**THIS SECTION FOR STAFF USE ONLY**

22a. What is the main reason for the patient's visit?

- Routine breast screening
- Follow-up to prior mammogram
- Self-referred for breast problems
- Physician referred for breast problems

b) Has the patient had any NEW breast changes since her last mammogram? (Fill in all that apply)

	BOTH	RIGHT	LEFT
Nipple Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lump	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain (describe below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (describe below)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Describe, give location and duration of NEW changes:

c) Were any of these changes present in the past 3 months?

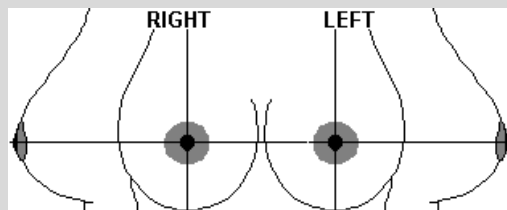
- Yes
- No

d) Are any of these changes present today?

- Yes
- No

e) Has a healthcare provider examined the patient's breasts since the onset of these concerns?

- Yes →  month -  year
- No



Technologist review initials: \_\_\_\_\_  
 Medical release for outside films initiated: Yes / Not Needed



Please provide a phone number and the best day/time to reach you:

May we leave a detailed message? Yes / No

Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Weekday/Time: \_\_\_\_\_

Affix label here

**PLEASE INFORM THE TECHNOLOGIST IF YOU ARE PREGNANT. For each response, please fill in the circle, with a pen, like this: ●**

1. What is today's date?

/  /      
 month day year

2a. Have you ever had a mammogram?

- Yes
- No → **If no, go to #3a**

b) If yes, when was your last mammogram? (Please give your best guess)

-      
 month year

c) Was your last mammogram done at GHC?

- Yes
- No

d) Do you currently weigh at least 10 pounds MORE or 10 pounds LESS than you did at your last mammogram?

- Yes, more
- Yes, less
- No

**Please answer the following questions to help us assess your CURRENT risk of breast cancer. We recognize that we may have asked you these questions in the past and the answers may not have changed, but it is important that you answer them each time you come in.**

3a. Have you ever been diagnosed with breast cancer?

- Yes, both breasts
- Yes, right breast
- Yes, left breast
- No → **If no, go to #4a**

b) If yes, when were you FIRST diagnosed with breast cancer? (Please give your best guess)

-      
 month year

c) If you have had more than one breast cancer diagnosis, when was your MOST RECENT?

-      
 month year

4a. Have you ever had a biopsy (tissue removed from your breast to test for cancer)? This does not include the removal of fluid from a cyst or a breast reduction.

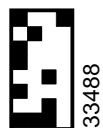
- Yes
- No → **If no, go to #5a**

b) If yes, how many times has this occurred?

- 1
- 2
- 3
- 4 or more
- Don't know

c) Which breast(s) was/were involved?

- Both breasts
- Right breast
- Left breast



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**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE**

**d) When was your FIRST breast biopsy?**

(Please give your best guess)

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year

**e) When was your MOST RECENT breast biopsy?**

(Please give your best guess)

--	--	--	--

year

**f) Was your most recent biopsy done at GHC?**

Yes

No

**5a. Have you EVER had any of the following breast procedures? (Fill in all that apply)**

	BOTH BREASTS	RIGHT BREAST	LEFT BREAST
Cyst aspiration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lumpectomy (for breast cancer)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mastectomy (for breast cancer treatment)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mastectomy (Prophylactic or NOT for breast cancer)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Radiation therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast reconstruction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast reduction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Breast implants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b><u>None of the above</u></b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**b) If you have had breast implants, are your breast implants still present?**

Yes, in both breasts

Yes, in the right breast

Yes, in the left breast

No

**6. When was the last time a health care provider examined your breasts for lumps with his/her hands?**

Within the last 3 months

4 - 12 months ago

More than 12 months ago

Never

Not sure

**7. How old were you when you had your FIRST menstrual period?**

10 or under

11

12

13

14

15 or older

Don't know

I have never had a menstrual period

**8a. Are you still having periods?**

Yes (include periods due to birth control pills)

Yes, but I am on female hormones (estrogen or progesterone; **not** birth control)

Yes, but they are irregular or less frequent

No

**b) If you are still having periods, when was the first day of your last menstrual period?**

1-7 days ago

8-14 days ago

15-21 days ago

22-35 days ago

more than 35 days ago

**c) If you are no longer having periods, how old were you when your menstrual periods stopped?**

Under age 30

30 - 39

40 - 49

50 - 54

55 or older

Don't know

**d) Why did your menstrual periods stop?**

Natural Menopause

Surgery

Birth control pills, patches, shots, or Norplant

Other reason:

Don't know

**e) If your periods stopped due to surgery, what kind of surgery did you have? (Fill in all that apply)**

Hysterectomy (removal of uterus)

Removal of one ovary

Removal of both ovaries

Don't know if ovaries were removed

**9a. Have you ever taken female hormones? (Include estrogen, progesterone, and hormones for breast cancer treatment. DO NOT include birth control pills, patches, shots, Norplant, IUDs, or fertility-enhancing hormones.)**

Yes

No ➔ **If no, go to #10a**

**b) How many years in all have you taken female hormones?**

Less than 1 year

5 - 9 years

1 - 2 years

10 - 14 years

3 - 4 years

15 years or more

**c) Are you currently taking any of the following hormones or medications? (Fill in all that apply)**

Hormone therapy

Both Estrogen and Progesterone/Progestin

Estrogen only

Progesterone/Progestin only

Tamoxifen (Nolvadex)

Raloxifene (Evista)

Aromatase inhibitors (Anastrozole/Arimidex, Letrozole/Femara, Exemestane/Aromasin)

Natural hormones (black cohosh, herbs, etc.)

Other hormones (do not include birth control)

Don't know

I am not currently taking female hormones

**10a. Have you ever given birth to a child?**

(Include all pregnancies that lasted at least 6 months, live births, still births, or cesarean sections.

**DO NOT** include miscarriages and abortions.)

Yes

No ➔ **If no, go to #11**

**b) How old were you when you first gave birth?**

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years old

**c) How many times have you given birth?**

1    2    3    4    5 or more

**11. Are you currently using birth control pills, patches, shots, a Mirena IUD, or Norplant?**

Yes

No

**12. Are you adopted?**

Yes

No

**13a. How many of your blood relatives (male or female, living or dead) have been diagnosed with breast cancer? (Fill in all that apply)**

	0	1	2	3 or more	N/A*	Don't know
Mother	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>
Sisters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daughters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grandmothers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
Aunts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Father	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>
Brothers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*Fill in N/A if you do not have any of these relatives.

**b) How many of your female blood relatives (living or dead) were diagnosed with breast cancer BEFORE AGE 50? (Fill in all that apply)**

	0	1	2	3 or more	N/A*	Don't know
Mother	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>
Sisters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daughters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Grandmothers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>
Aunts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*Fill in N/A if you do not have any of these relatives.

**14a. How many of your blood relatives (living or dead) have been diagnosed with OVARIAN CANCER? (Fill in all that apply)**

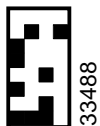
	0	1	2	3 or more	N/A*	Don't know
Mother	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>
Sisters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daughters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*Fill in N/A if you do not have any of these relatives.

**b) How many of your blood relatives (living or dead) were diagnosed with OVARIAN CANCER BEFORE AGE 45? (Fill in all that apply)**

	0	1	2	3 or more	N/A*	Don't know
Mother	<input type="radio"/>	<input type="radio"/>				<input type="radio"/>
Sisters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Daughters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\*Fill in N/A if you do not have any of these relatives.



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