

BREAST QUESTIONNAIRE

Patient Name: _____ Date: _____

1. What is your particular breast problem? _____

2. Does this run in female members of your family? _____
If so, who? _____
3. What is your height? _____ Weight? _____
4. What size bra do you wear? _____ Padded or unpadded? _____
5. How many children do you have? _____ What are their ages? _____
6. Did you breast feed? _____ Bottle Feed? _____
Out of choice? _____
7. Did your breasts change size with pregnancy? _____
If so, how much (In bra size)? _____
8. Have you ever had any breast disease or breast tumors? _____
If so, please explain (Type, Date of Surgery, Doctor) _____

9. Has anyone in your family ever had any breast disease or breast tumors? _____
If so, please specify _____
10. How is your general health? _____
11. Are you taking any birth control pills now? _____
If so, please specify _____