THE BONE & BREAST CARE CENTRE
PATIENT QUESTIONNAIRE

NAME _____ AGE _____

PREVIOUS MAMMOGRAM? NO/YES, where _____ when _____

DEMOGRAPHICS (This information is required for statistical purposes only)

Race _____ Religion _____ Marital Status _____

Bra size _____

1a. Do you have any children? Yes/No
If yes : Number of children _____
Did you breast feed? Yes/No
Age at first pregnancy ___ years
Smoking Yes/No
Alcohol Yes/No

1b. Have you been treated for infertility? Yes/No

2. How old were you when your periods started? ____ years

3. Have you ever taken the oral contraceptive pill? Yes/No
If yes : Age when first taken? ____ years
Are you taking it now? Yes/No

4. Have you had a hysterectomy? Yes/No
If yes : How old were you? ____ years
Do you still have your ovaries? Yes/No

5. Are you still having regular periods? Yes/No
If no : Age when periods stopped / changed? ____ years

6. Have you ever been on hormone replacement therapy? Yes/No
If yes : How long taken for? _____
Age first taken _____ years
Are you taking it now? Yes/No
Brand taken _____

7. Have you had a previous breast operation? Yes/No (Cancer/Implants/Reduction - Date: _____)

If yes : Give details _____

_____

Details of family history of breast/ovarian cancer :

RELATION	AGE AT DIAGNOSIS	NO. OF BREASTS INVOLVED	ALIVE YES/NO	AGE AT DEATH	DEATH FROM BREAST CANCER YES/NO

8. Personal Cancers: _____

9. Referred by: _____

10. Symptoms: _____