Highland Medical, P.C.
BREAST SURGERY

BREAST QUESTIONNAIRE

Name:_____Date of birth: _____ Date: _____

Reason for visit:_____

PART 1: (patient)

Internist/General Practitioner:_____

OB/Gyn _____

Age: _____ First and last pregnancy (your ages): _____

Total number of pregnancies: _____When was your last mammogram: _____

Last period (date or age): _____ First period (age):_____

	YES	NO
Do you take hormones/birth control pills?		
Do you practice self-breast examinations?		
Did you ever have a breast biopsy?		
Have you ever had a discharge from your nipples?		
Have you ever had a tenderness or lumps?		
Do you have a family history of breast cancer? (relation to you, age at diagnosis, duration of illness?)		

PART 2: (physician)

Mammogram Date	Positive	Negative	Comments

Physical Exam:	RIGHT	LEFT
Masses		
Adenopathy		
Skin Changes		
Nipple Discharge		

Comments/Recommendations: