

## Breast Health Assessment Questionnaire

Name \_\_\_\_\_

Age \_\_\_\_\_

Race \_\_\_\_\_

Age at first period \_\_\_\_\_

Date of last menstrual cycle \_\_\_\_\_

Age at first full term pregnancy \_\_\_\_\_

Did you breastfeed any of your children?

Yes

No

Age at menopause \_\_\_\_\_

Did you ever take hormone replacement?

Yes

No

If so, for how long? \_\_\_\_\_

Have you undergone any breast biopsies?

Yes

No

Which side?

Left

Right

Both

What were the results? \_\_\_\_\_

Have you undergone any gynecologic surgery?

Yes

No

What procedures? \_\_\_\_\_

Any family members (either side) diagnosed with breast cancer?

Yes

No

\_\_\_\_\_ Mother

\_\_\_\_\_ Grandmother(s)

\_\_\_\_\_ Sister(s)

\_\_\_\_\_ Aunt(s)

\_\_\_\_\_ Cousin(s)

Any family history of other types of cancer (esp. colon, ovarian, uterine, pancreas, prostate, brain)?

Yes

No

If so, what type? \_\_\_\_\_

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