



BREAST QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

1. What is your particular breast concern? _____
2. Does this run in female members of your family? _____ If yes, who? _____
3. What is your height? _____ Weight? _____ Bra Size? _____ Padded or Unpadded
4. How old were you when you began menstruating? _____ Date of your last period _____
5. How many times have you been pregnant? _____ How many children do you have? _____
6. Did you breast feed? _____ If yes, for how long? _____
7. Did your breast size change with pregnancy? _____ If yes, how much? _____
8. When was your last mammogram? _____ Was it normal? _____
9. Have you ever been diagnosed with any breast diseases or breast tumors? _____
If yes, please explain (type, date of surgery if any, and doctor) _____

10. Has anyone in your family had any breast disease or tumors? _____
11. How is your general health? Excellent _____ Good _____ Fair _____ Poor _____
12. Have you ever had any major illnesses or injuries? _____
If yes, please specify _____
13. Do you have any unusual bleeding tendencies? _____ If yes, please explain _____

14. Have you ever taken any hormones or birth control pills on a regular basis? _____
If yes, please list _____
15. Do you smoke? _____ If yes, how much? _____
Do you drink? _____ If yes, how much? _____

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