![affidea logo]

# Brest Health questionnaire

First and last name: _____     Date of birth: _____
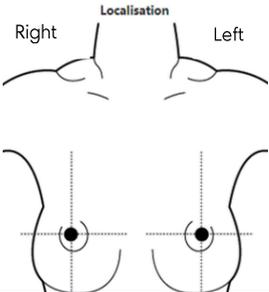
Have you ever had a mammogram?     □Yes          □ No          If yes, when? _____          Where? _____

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## Symptoms:

Are you currently experiencing breast problems?          □ Yes     □ No

- If **so**, in which region and what problem?

  *Mark the relevant area with a cross on the drawing*

  Localisation
  Right          Left

  □ Nodule

  □ Pain

  □ Nipple retraction

  □ Other: _____

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## Personal history :

| | | |
|---|---|---|
| Are you pregnant or likely to become pregnant? | □ Yes | □ No |
| Are you or have you ever been breast-feeding? | □ Yes | □ No |
| Contraception : | □ Yes | □ No |

Number of pregnancies : _____
Number of births : _____
Date of last menstrual period: _____

Menopause:          □ Yes          □ No
- If **so**, are you taking hormone therapy?          □ Yes          □ No

Have you had any of the following operations?
- Hysterectomy (removal of uterus, tubes)          □ Yes          □ No
- Ovariectomy (removal of ovaries)          □ Yes          □ No
- Breasts (cyst/nodule biopsy, breast reduction)          □ Yes          □ No
- Other: _____

Do you wear breast implants?          □ Yes          □ No
- If **yes**,
  What type of prosthesis?          □ Silicone          □ Saline solution
  Year of implementation:          _____
  Is there a history of ruptures?          □ Yes          □ No

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## Positive family history:

Does breast cancer run in your family?          □ Yes          □ No

- If **so**, which family member is involved?

| | □ Mother | □ Sister(s) | □ Girl (s) | □ Other: _____ |
|---|---|---|---|---|
| More than 50 years | | | | |
| Less than 50 years | | | | |

Are there any other cancers in your family?
□ Uterus / ovaries          □ Colon          □ Pancreas          □ Prostate

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## Breast cancer:

Do you have or have you ever had breast cancer?          □ Yes     □ No

- If **yes**,
  In which year:                                        _____

  Which side of the breast?          □ Left          □ Right          □ Both sides

  Have you had surgery?          □ Yes     □ No

  What type of surgery?          □ Mastectomy
                                 □ Tumorectomy
                                 □ Axillary curettage

  Have you had any treatment?          □ Radiotherapy
                                       □ Chemotherapy
                                       □ Hormone therapy
                                       □ Immunotherapy

  Have you undergone genetic screening?          □ Yes     □ No
  Is it?          □ Positive □ Negative

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Date: _____          Signature: _____