Oregon Surgical Wellness | WVCI Willamette Valley Cancer Institute and Research Center

New Patient Breast Questionnaire

Name: _____ **DOB:** _____

1. Age of first period: _____ years old
2. Menopausal? ☐ Yes ☐ No
3. Age of first live birth? _____ years old ☐ N/A
4. Number of children: _____
5. Did you breastfeed? ☐ Yes ☐ No
6. History of Oral Contraceptive use? ☐ Previous ☐ Current ☐ Never
7. History of Hormone Replacement Therapy? ☐ Previous ☐ Current ☐ Never
8. Do you have your ovaries? ☐ Both Intact ☐ 1 Removed: L / R ☐ Both Removed
9. Any nipple discharge? ☐ Yes – if yes, color/consistency: _____ ☐ No
10. Number of breast biopsies: _____ (Left: _____ Right: _____)
11. History of trauma to the breasts? ☐ Yes – explain: _____ ☐ No
12. Have any relatives tested positive for genetic mutations?

☐ Yes explain: _____ ☐ No

13. Family History of Breast Cancer?

☐ Yes - explain: _____ ☐ No

14. If yes to question 15 and a first-degree relative (mom, sibling, child) had breast cancer at what age were they diagnosed? _____
15. Are you of Ashkenazi Jewish decent? ☐ Yes ☐ No ☐ Decline to Respond