

# BREAST HEALTH HISTORY QUESTIONNAIRE

## San Francisco Mammography Registry

### Important Instructions

- Use blue or black ball point pen - no felt tips
- Fill in circles completely - no ✓'s or X's
- This information is used to help the radiologist interpret your mammogram.
- With your permission, this information also will be used for research purposes by the SFMR that may lead to improvements in breast health. If you do not wish to have your information included in research, please fill in the circle.

- 1
- 2
- 3
- 4
- 5

Correct Mark ● Incorrect Marks ✗ ⊗ ⊖ ⊙

### 1 Have you ever had a mammogram?

- No  Yes, *If yes:*

When was your last mammogram?

- Less than 1 year ago  2 to 3 years ago  
 1 to 2 years ago  4 or more years ago

Where was it done? \_\_\_\_\_

### 2 Have you had a clinical breast exam within the last 3 months?

- No  Yes, *If yes:*

Did your doctor discover a new or unusual lump?

- No  Yes

### 3 Have you noticed any of the following changes in your breasts?

	Present Today?		In the last 3 months?	
	Right breast	Left breast	Right breast	Left breast
Lump (new or unusual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 4 Has a doctor ever told you that you have breast cancer?

- No  Yes, *If yes:*  
 Right breast  Left breast  Both breasts

### 5 Has your mother, sister or daughter ever been diagnosed with breast cancer?

	No		Yes		Was she diagnosed before age 50? Yes
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mother?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 6 Have you ever given birth?

- No  Yes, *If Yes:*

How old were you when your first child was born?

- Under age 20  30 - 39 years old  
 20 - 29 years old  40 or older

### 7 Have your menstrual periods stopped permanently?

- No  
 Not sure, periods less frequent  
 Yes: Periods stopped naturally  
 Yes: But now have periods induced by hormones  
 Yes: Uterus removed by surgery  
 Yes: Uterus *and* both ovaries removed by surgery  
 Yes: Other: \_\_\_\_\_

If yes, how old were you when your periods stopped?

- Under age 30  40 - 44  50 - 54  
 30 - 39  45 - 49  55 or older

### 8 Are you currently taking hormone replacement (female hormones prescribed for women after menopause)?

- No  Yes, for less than five years  
 Yes, for five years or more

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
(street)  
 \_\_\_\_\_  
(city, state, zip)

### 9 Are you currently taking any of the following medications?

- Tamoxifen (Nolvadex)  Letrozole (Femara)  
 Raloxifene (Evista)  Hormones for birth control  
 Anastrozole (Arimidex)  None

### 10 Which breast surgeries or treatments have you had?

Surgery/Treatments	Right breast	Left breast	Date(s)
Fine needle aspiration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Core biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgical biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lumpectomy for cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mastectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast reduction	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast implants ( <i>presently</i> )	<input type="checkbox"/>	<input type="checkbox"/>	_____

### 11 How tall are you in feet and inches?

FT.	INCH.
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
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### 12 How much do you weigh in pounds?

POUNDS		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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### 13 On average, about how many alcoholic drinks do you have per day?

- None  About two a day  
 Less than one or one a day  Three or more a day

*The following questions are optional but will be very helpful for research in breast health.*

### 14 Racial or ethnic background: (fill in all that apply)

- African-American/Black  Japanese  
 Caucasian/White  Filipina  
 Hispanic/Latina  Vietnamese  
 American Indian  Other Asian  
 Chinese  Other, non-Asian

### 15 How many years of schooling have you had?

- Some high school or less  
 High school graduate  
 Some college or technical school  
 College graduate or more

### 16 Are you willing to be contacted in the future to be invited to participate in studies related to breast health?

- Yes  No **Thank You!**

**FOR TECHNOLOGIST USE ONLY**

Right Left

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- ②
- ③
- ④
- ⑤

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
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