**PATIENT INFORMATION FORM**

1. Have you had any of the following breast changes in the last 3 months? (check all that apply)
   - Lump
   - Nipple discharge
   - Pain
   - Other, describe: ______________________
   - No changes

2. What is the main reason for your visit today? (check one)
   - Routine screening
   - Follow-up to routine screening exam
   - Concerns about breast problems

   IF CONCERNS: Who first noticed your breast problems?
   - Self
   - Physician or other healthcare provider
   - Other

3. When was your last mammogram?
   - Date: __ __ / __ __ / __ __ __ __ (month/year)
   - I never had a mammogram

4. When did a health care provider last examine your breasts?
   - Never
   - Within the last 3 months
   - 4 months to 1 year ago
   - More than 1 year ago
   - Not sure

5. Have you ever been diagnosed with breast cancer?
   - No
   - Yes

   IF YES, please answer the following questions:
   - Which breast(s)? Left Right Both
   - At what age were you first diagnosed? __ __ years old
   - OR: Date of diagnosis: __ __ / __ __ / __ __ __ __ (month/year)

6. Have you had any of the following breast procedures? (check all that apply)
   - Fine needle or cyst aspiration
   - Biopsy
   - Lumpectomy (for breast cancer)
   - Mastectomy
   - Radiation therapy
   - Breast reconstruction
   - Breast reduction
   - Breast implants (still present)
   - I have not had any of the above procedures

7. Have any blood relatives been diagnosed with breast cancer?
   - Mother: No Yes Not sure
   - Sister: No Yes One 2 or more Not sure
   - Daughter: No Yes One 2 or more Not sure

   IF YES, were any diagnosed before age 50?
   - Mother: No Yes Not sure
   - Sister: No Yes One 2 or more Not sure
   - Daughter: No Yes One 2 or more Not sure

8. Have you or a blood relative ever been diagnosed with ovarian cancer?
   - No
   - Self
   - Mother, sister, or daughter
   - Other relative
   - Not sure

9. How old were you when you had your first period?
   - 12 or younger
   - 13
   - 14
   - 15 or older
   - Not sure
   - Never started my period

10. Are you currently taking any of the following hormone medications? (check all that apply)
   - Hormone replacement therapy (HRT) (e.g. Premarin)
   - Other hormone: ______________________

11. Have your menstrual periods stopped permanently?
   - No
   - Yes, natural menopause
   - Yes, surgical procedure
   - Yes, other reason
   - Not sure

   IF NO or NOT SURE, when was the first day of your last period? __ __ / __ __ / __ __ __ __ (month/year)

12. Have you ever given birth?
   - No
   - Yes

   IF YES: How old were you when your first child was born? __ __ years old

13. What is your current height? __ __ __ feet __ __ __ inches

14. What is your current weight? __ __ __ pounds

15. Are you of Hispanic, Spanish, or Latino origin?
   - No
   - Yes

16. What is your racial or ethnic background? (check all that apply)
   - White
   - Black or African American
   - Asian
   - Native Hawaiian or other Pacific Islander
   - Other, Hispanic or Latino origin: ______________________

17. What is the highest level of education you have completed? (check one)
   - Less than high school graduate
   - High school graduate or GED
   - Some college or technical school
   - College or post-college graduate

18. What kind of healthcare coverage do you have? (check all that apply)
   - Medicare
   - Medicaid
   - Private insurance
   - Managed care (such as HMO or PPO)
   - Other, describe: ______________________

   - Not sure
   - I have no coverage

Thank you for taking time to complete this questionnaire.