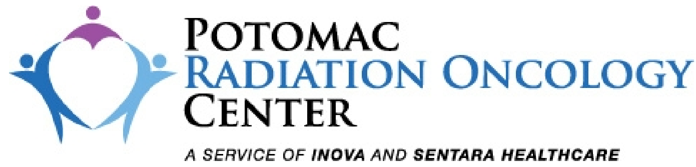

Breast Cancer Questionnaire

Patient's Name: ________________________________Today's Date: ________________

1. Please give the name of the doctor who has referred you to Potomac Radiation Oncology Center :____

2. How old were you when you had your first period?______________________________

3. How many pregnancies have you had, if any?____________________________________
   How may live births?____

4. How old were you at the birth of your first child?_______________________________

5. Did you breast feed your children?____

6. Have you ever taken birth control (pills or Depo Provera shots?) No __________ If yes, for how long?____

7. Have you gone through menopause? No__________ If yes, at what age? _____________
   ____

8. Are you taking, or have taken hormone replacement? No__________ If yes, what have you taken and for how long?____

9. Do you perform breast self-examinations? Yes________________ No ________________

10. Do you have any relatives with breast cancer? No__________ If yes, how are they related to you and how old were they when diagnosed, and what treatment was performed?
    ____
    ____
    ____

11. Do you have any skin conditions or collagen vascular disorders such as lupus or scleroderma?____

12. Have you ever had prior radiation treatments? If so, please describe and give dates of treatment.____
    ____
    ____