SASKATOON HEALTH REGION
Saskatoon Saskatchewan
Saskatoon City Hospital

BREAST HEALTH PROGRAM

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PATIENT QUESTIONNAIRE

BREAST SYMPTOMS & HISTORY

No **Yes**

1. Have you experienced any of the following breast symptoms? *If yes, please indicate:*

Symptom	Which breast?		When? Within the past:			
	Right Breast	Left Breast	<3 Months	<6 Months	<24 Months	> 5 Years
Abnormal imaging	○	○	○	○	○	○
Axillary mass	○	○	○	○	○	○
Breast lump	○	○	○	○	○	○
Breast pain	○	○	○	○	○	○
Nipple discharge	○	○	○	○	○	○
Skin changes	○	○	○	○	○	○
Other_____	○	○	○	○	○	○

2. Have you had a clinical breast exam within the last 3 months? If yes:

Other_____ ○ No ○ Yes

3. Have you ever had a mammogram? If yes:

	Which breast?		Date of Last Mammogram
	Right Breast	Left Breast	
Last mammogram	○	○	_____

4. Have you ever had a breast biopsy? If yes, please indicate:

	Which breast?		How many?		Date of Last Biopsy
	Right Breast	Left Breast	1	>1	
Biopsy	○	○	○	○	_____
Biopsy with atypical hyperplasia	○	○	○	○	_____

5. Have you ever been told that you have breast cancer or ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS)? If yes:

	Which breast?		Date Diagnosed
	Right Breast	Left Breast	
Breast cancer	○	○	_____
DCIS	○	○	_____
LCIS	○	○	_____

6. Have you ever had other breast surgeries or treatments? If yes, please indicate:

	Which breast?		Date of Last Surgery / Treatment
	Right Breast	Left Breast	
Fine needle aspiration	○	○	_____
Lumpectomy for cancer	○	○	_____
Mastectomy	○	○	_____
Radiation therapy	○	○	_____
Breast reconstruction	○	○	_____
Breast implants (presently)	○	○	_____
Other_____	○	○	_____

(Patient Name) (PSN)

MEDICAL HISTORY

No Yes

7. Have you ever been diagnosed with a medical condition? If yes:

	Condition	Year
○	Heart Disease	_____
○	Diabetes	_____
○	Cancer	_____
○	High Blood Pressure	_____
○	Asthma/COPD	_____

8. Have you ever had any surgeries? If yes, please indicate:

	Condition	Year		Condition	Year		Condition	Year
○	Adenoidectomy	___	○	Ectopic Pregnancy	___	○	Laparoscopy	___
○	Appendectomy	___	○	Endometrial Ablation	___	○	LASIK (eye)	___
○	Back Surgery	___	○	Gallbladder	___	○	Ovary Removal	___
○	Bladder lift	___	○	Gastric Bypass	___	○	Pacemaker Implant	___
○	C/Section	___	○	Hemorrhoid	___	○	Shoulder	___
○	Colon Resection	___	○	Hernia	___	○	Sinus	___
○	Colonoscopy	___	○	Hip replacement	___	○	Splenectomy	___
○	Coronary Bypass	___	○	Hysteroscopy	___	○	Thyroidectomy	___
○	Cystoscopy	___	○	Hysterectomy	___	○	Tonsillectomy	___
○	D&C	___	○	Knee	___	○	_____	___
○	_____	___	○	_____	___	○	_____	___
○	_____	___	○	_____	___	○	_____	___

9. Have you ever received any radiation therapy? If yes:

	Condition	Year
○	_____	_____
○	_____	_____

10. Do you have any allergies? If yes, please complete the allergy / intolerance record.

11. Do you take any medications? If yes, please list:

REPRODUCTIVE HISTORY

No Yes

12. Are you currently pregnant?

13. Are you currently breast-feeding?

14. Have you ever been pregnant? If yes, please indicate:

	Total
Number of pregnancies	_____
Number of births	_____
Number of miscarriages	_____
Age during your first pregnancy	_____

(Patient Name) (PSN)

GYNECOLOGICAL HISTORY

No	Yes	
		15. Age at first period _____
○	○	**16. Have your menstrual periods stopped? Please indicate:**
		Date of last period _____
		Age when your periods stopped ○ <30 ○ 30-39 ○ 40-44 ○ 45-49 ○ 50-54 ○ ≥ 55
		Reason periods stopped ○ Naturally ○ By surgery / drugs
○	○	**17. Have you ever taken hormone replacement therapy? If yes, please indicate:**
		Currently taking hormone replacement ○ No ○ Yes
		Length of time taken ○ <5 years ○ > 5 years
		Type of therapy ○ Estrogen ○ Progesterone ○ Both ○ Unknown
		Age when stopped taking _____
○	○	**18. Have you ever taken hormonal contraceptives? If yes, please indicate:**
		Length of time taken _____

LIFESTYLE HISTORY

No	Yes	
○	○	**19. Have you ever smoked? If yes, please indicate:**
		➢ Do you currently smoke? ○ No ○ Yes
		➢ How many years have you or did you smoke? _____
		➢ How long ago did you quit? _____
		➢ How many packs/day do you/did you smoke? _____

GENETIC / ETHNIC BACKGROUND

No	Yes	
○	○	**20. Have you ever undergone genetic testing for breast cancer? If yes, please indicate:**

	BRCA1	BRCA2	Neither	Other	Date Assessed
Results indicated	○	○	○	○ _____	_____

No	Yes	
○	○	**21. Has anyone in your family undergone genetic testing for breast cancer? If yes:**

Relationship	BRCA1	BRCA2	Neither	Other	Date Assessed
_____	○	○	○	○ _____	_____
_____	○	○	○	○ _____	_____

No	Yes	
○	○	**22. Are you of Jewish ancestry?**
		23. What is your racial or ethnic background: (fill in all that apply)

○ Asian (South)	○ Caucasian/White	○ Inuit	○ Metis
○ Asian (Southeast)	○ Chinese	○ Japanese	○ Other
○ Asian (West)	○ Filipino	○ Korean	
○ Black	○ First Nations / North American Indian	○ Latin American	

(Patient Name) (PSN)

FAMILY CANCER HISTORY

No	Yes	
○	○	**24. Have any of your immediate family members been diagnosed with cancer? [include mother, father, brother, sister, son, daughter] If yes:**

Cancer Diagnosis								Status		Age	Age at Diagnosis			Cause of Death		
Breast	Colon	Ovarian	Pancreatic	Prostate	Uterine	Other	Relationship	Alive	Deceased	Age Now or at Death	<35	<50	>50	From Cancer	Not From Cancer	Of Jewish Ancestry
○	○	○	○	○	○	________		○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	______	○	○	○	○	○	○

No	Yes	
○	○	**25. Have any other relatives been diagnosed with cancer? [include grandmother, grandfather, aunt, uncle, niece, nephew, granddaughter, grandson, male/female cousin, great uncle, great aunt] If yes:**

Cancer Diagnosis							Relationship			Status		Age	Age at Diagnosis			Cause of Death		
Breast	Colon	Ovarian	Pancreatic	Prostate	Uterine	Other	Relation	Maternal	Paternal	Alive	Deceased	Age Now or at Death	<35	<50	>50	From Cancer	Not From Cancer	Of Jewish Ancestry
○	○	○	○	○	○	________		○	○	○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	○	○	______	○	○	○	○	○	○
○	○	○	○	○	○	________		○	○	○	○	______	○	○	○	○	○	○

SIGNATURE

NAME	DATE