UCLA Health

MRN:
Patient Name:

(Patient Label)

BREAST CENTER
HEALTH QUESTIONNAIRE

1. Main reason for this visit:_____
2. Who referred you to our office:_____
3. Please list any treating physicians:_____
4. Age: _____ Height: _____ Weight: _____ Bra Size (if female):_____

BREAST HISTORY

1. Do you perform breast self-examinations? ☐**Yes** ☐**No**
   If so, how often? _____
2. Are you comfortable performing breast self-examinations? ☐**Yes** ☐**No**
   If no, why? _____
3. Have you noticed any lump, nipple discharge, skin or nipple rash, indentation, pain or other change? ☐**Yes** ☐**No**
   If yes, please explain: _____
4. Have you ever been diagnosed with breast cancer? ☐**Yes** ☐**No**

BREAST IMAGING

1. Do you undergo regular mammogram exams? ☐**Yes** ☐**No** If so, how often?_____
2. When was your last mammogram?_____ What facility?_____
3. When was your last ultrasound? _____ What facility?_____
4. When was your last MRI? _____ What facility?_____
5. Other breast imaging: _____

RISK ASSESSMENT

1. Have any 1st degree relatives (mother, sister, daughter) been diagnosed with breast cancer?
   ☐**Yes** ☐**No**
   If yes, which relative, and what age were they diagnosed?_____
2. Have any 1st degree relatives (mother, sister, daughter) been diagnosed with ovarian cancer?
   ☐**Yes** ☐**No**
   If yes, which relative, and what age were they diagnosed?_____
3. Have you ever had chest radiation with the exception of breast cancer treatment (for example Hodgkin's Lymphoma)? ☐**Yes** ☐**No**
   If yes, what was the diagnosis, how old were you?_____
4. Have you had any other type of cancer? ☐**Yes** ☐**No**
   If yes, please provide details (type, age at diagnosis, treatment):_____

_____

5. Have you or any relatives been tested for or diagnosed with a genetic mutation (such as BRCA 1/2)? ☐**Yes** ☐**No** If yes, please provide details: _____

_____

UCLA Health

MRN:
Patient Name:

(Patient Label)

BREAST CENTER
HEALTH QUESTIONNAIRE

GYNECOLOGIC HISTORY (if male, please skip to next section)

1. How old were you at menarche (first period)? _____
2. When was your last period? _____
3. If you are having periods, are they regular? Please describe:_____
4. Is there a possibility that you may be pregnant? ☐**Yes** ☐**No** ☐**Not Sure**
5. How many times have you been pregnant?_____ How many children do you have?_____
   How old were you when you had your first child? _____
6. Did you breast feed? ☐**Yes** ☐**No** If yes, for how long? _____
   Did you have any difficulties breast feeding? _____
7. Have you had a hysterectomy (removal of the uterus)? ☐**Yes** ☐**No**
   If yes, when and why? _____
8. Have you had your ovaries removed (one or both)? ☐**Yes** ☐**No**
   If yes, when and why? _____
9. Do you currently or have you used birth control pills, a hormone-secreting IUD, or hormone replacement therapy (estrogen, progesterone, testosterone, DHEA) including bio-identical hormones? ☐**Yes** ☐**No**
   If yes, please provide details (type, age, how many years): _____
   _____
10. When was your last pap and pelvic exam? _____ Were the results normal? ☐**Yes** ☐**No**

OTHER MEDICAL HISTORY & REVIEW OF SYSTEMS

Medical History – Please list past and current conditions (diabetes, hypertension, etc.)

Condition	Treating Physician

1. Do you have a pacemaker? ☐**Yes** ☐**No**
2. Have you ever had a colonoscopy? ☐**Yes** ☐**No** If yes, was it normal? ☐**Yes** ☐**No**

Current Medications (include dose/amount per day)

Medication	Dose/Frequency	Prescribing Physician

UCLA Health

BREAST CENTER
HEALTH QUESTIONNAIRE

MRN:
Patient Name:

(Patient Label)

Allergies & Medication Reactions (medications, iodine, shellfish, contrast dye, latex, etc.)

Allergy/Medication	Reaction

Surgical History – Please list all surgeries (include breast biopsies, implants, or aspirations)

Surgery	Date	Physician/Location	Pathology Results (if any)

System Review – Please note any persistent symptoms, past problems, or concerns:

General	**Yes**	**No**	**Genitourinary**	**Yes**	**No**
Fevers			Frequent urination		
Night sweats			Night time urination		
Chills			Burning or painful urination		
Weight gain or loss			Blood in urine		
Chronic fatigue			Kidney stones		
Stress			Sexually transmitted disease		
Pain			Change in sexual function/interest		
			Uterine or ovarian tumors		
			Irregular or painful menstrual periods		
			Uterine bleeding after menopause		
			Prostate enlargement or other problem		

Skin	**Yes**	**No**	**Musculoskeletal**	**Yes**	**No**
Hives or itching			Joint stiffness, pain or swelling		
Rash or eczema			Muscle pain, cramping, weakness		
New / changing mole, other skin lesion			Injuries or joint fractures		
Non healing wound or ulcer			Hand or arm swelling		
			Bone pain		
			Back pain		

UCLA Health

BREAST CENTER
HEALTH QUESTIONNAIRE

MRN:
Patient Name:

(Patient Label)

Eyes, Ears, Nose and Throat	Yes	No	Psychiatric	Yes	No
Eye disease or injury			Depression		
Glasses or contact lenses			Anxiety, nervousness		
Change in vision, blurry or double vision			Hallucinations		
Change in hearing			Paranoia		
Nose bleeds, bleeding gums			Memory loss, confusion		
Sinus problems			Change In sleep patterns		
Voice changes, frequent sore throat					

Respiratory	Yes	No	Neurological	Yes	No
Shortness of breath			Fainting		
Cough			Convulsions, seizures		
Wheezing / asthma			Headaches		
Non healing wound or ulcer			Change in memory, concentration		
			Numbness, tingling, weakness, paralysis		

Cardiovascular	Yes	No	Hematologic	Yes	No
Chest pain or palpitations			Anemia		
Shortness of breath when lying down			Excessive bleeding		
Difficulty walking 2 blocks			Abnormal bruising or bleeding		
Swelling of hands, feet, ankles			Swollen lymph nodes (glands)		
Blood clots					
Heart murmur					

Gastrointestinal	Yes	No	Endocrine	Yes	No
Heartburn, reflux			Excessive thirst or urination		
Black or bloody stool			Intolerance to heat / cold		
Constipation, diarrhea, change in stools			Thyroid problems		
Nausea, vomiting					
Change in appetite					

UCLA Health

BREAST CENTER
HEALTH QUESTIONNAIRE

MRN:
Patient Name:

(Patient Label)

Immunology/Allergy	Yes	No		Yes	No
Frequent cold or flu			Environmental or seasonal allergies		

FAMILY HISTORY

Relative	Current age, if living	Age at death, if deceased	Medical Problems	History of cancer, type, treatment	Age at cancer diagnosis

SOCIAL HISTORY / LIFESTYLE

Demographics:

1. What do you consider to be your race / ethnicity? Please check all that apply:

____ Ashkenazi Jewish
____ Spanish / Hispanic / Latina
____ African American
____ East Asian / Pacific Islander
____ European (including German, Dutch, Polish, Italian, French, Irish)
____ Other: _____
____ Not Known
____ American Indian, Aleutian, Eskimo
____ Armenian
____ Middle Eastern
____ Russian

2. Marital Status: ____ Single ____ Married ____ Domestic Partner ____ Separated ____Divorced ____ Widowed

3. Does anyone live at home with you? ☐**Yes** ☐**No**

If yes, please list: _____

4. Highest level of education:

____Graduate / Professional school
____ Other school beyond high school
____ High school diploma / GED
____ Other:_____
____ Some college or Associate degree
____ College degree
____ Some high school

5. What is your current occupation?_____

6. How many hours / week do you work? _____

UCLA Health

BREAST CENTER
HEALTH QUESTIONNAIRE

MRN:
Patient Name:

(Patient Label)

7. Do you exercise at all? ☐**Yes** ☐**No**
   If yes, how frequently? __less than one hr / week __1-3 hrs / week __more than 4 hrs / week
   If yes, what intensity? ___low ___moderate ___high
   What type(s) of exercise?_____
8. How is your overall diet and are you on a special diet? (fairly healthy, portions too large, high sugar intake, high processed food intake, etc.)_____
   _____
9. Do you consume caffeine? ☐**Yes** ☐**No** How much/what type? _____
10. Which best describes your current alcohol use?
    ____ Never ____ Rare (few drinks per year) ____ Few drinks per month
    ____ Few drinks per week ____ At least one drink most days
11. Do you have a history of alcohol abuse? ☐**Yes** ☐**No**
12. Have you ever smoked? ☐**Yes** ☐**No**
    If yes, please describe (current, past, how many packs, age):_____
13. Have you ever used recreational drugs? ☐**Yes** ☐**No**
    If yes, please describe (current, past, type, age):_____

The information provided in this questionnaire is true and complete to the best of my knowledge. I understand that the accuracy of the information I have provided is important to my physician and my healthcare team in order to develop an individualized care plan for me.

_____ _____
Patient or Representative Signature Date

_____ _____
Print Name Relationship to Patient

_____ _____ _____
Interpreter (if applicable) Interpreter ID # Date

_____ _____
Physician Signature Date
