Thermography Of Miami, LLC

Breast Questionnaire

Name: _____ D.O.B. ____/____/_____

		YES	NO
1.	Do you have any close relative who has had breast cancer?	☐	☐
2.	Have you ever been diagnosed with breast cancer?	☐	☐
3.	Have you ever been diagnosed with any other breast disease (fibrocystic)	☐	☐
4.	Have you had any biopsies or surgeries to your breasts?	☐	☐
5.	Have you had any breast cosmetic surgery or implants?	☐	☐
6.	Have you had a mammogram in the past 12 months?	☐	☐
7.	Have you had a mammogram in the past 5 years?	☐	☐
8.	Have you had abnormal results from any breast testing?	☐	☐
9.	Have you ever taken a contraceptive pill for more than 1 year?	☐	☐
10.	Have you suffered with cancer of the womb?	☐	☐
11.	Have you ever had hormone replacement therapy?	☐	☐
12.	Do you have an annual physical examination by a doctor?	☐	☐
13.	Do you perform a monthly breast self-exam?	☐	☐

14. How many mammograms have you had in total? _____
15. What was your age when you had your first mammogram? _____
16. How many births have you had? _____ Your age at birth of first child _____
17. Did you breast feed? Yes __ No ___. If yes, approximately for how long? _____
18. Did your periods start before the age of 12? Yes ___ No ___.
    Or finish after the age of 50? Yes ___ No ___.
19. Do you smoke? Yes __ Never ___ Not in last 12 months __ Not in last 5 yrs. __

Have you recently had any of the following symptoms?

	Left Breast	Right Breast
Pain	☐	☐
Tenderness	☐	☐
Lumps	☐	☐
Change in breast size	☐	☐
Areas of skin thickening or dimpling	☐	☐
Secretions of the nipple	☐	☐

Patient Disclosure

All information given is confidential and correct to the best of my knowledge.

Signature: _____ Date: ____/___/_____