ATLANTA SURGERY ASSOCIATES LLC

BREAST QUESTIONNAIRE

Patient Name_____ Date_____

Age_____ DOB_____ Referring Physician_____

Reason for Visit_____

Family History of Breast Cancer □ Self □Mother □Sister □Daughter □Aunt □None

When Was Your Last Mammogram? □ None Date_____ Facility_____

When Was Your Last Ultrasound? □ None Date_____ Facility_____

Any Breast Biopsies? □None □ Surgical Biopsy □ Stereotactic Biopsy □Needle Biopsy

□ Right □ Left

Date_____ Results _____
Date_____ Results _____

Any Breast Surgery? □ None □ Mastectomy □Right □Left Date_____ Diagnosis_____

□ Lumpectomy □Right □Left Date_____ Diagnosis_____

□ Implants □Reduction □Incision and Drainage for Abscess

Gynecological History

Number of children_____ Age at birth of first child_____

How many children did you breastfeed? _____ Are you currently breastfeeding? □ Yes □No

Are you pregnant? □ Yes □No Due Date_____ Birth Control? □ Yes □No Type_____

Age at menopause _____ Hysterectomy □ Yes □No Full _____ Partial_____

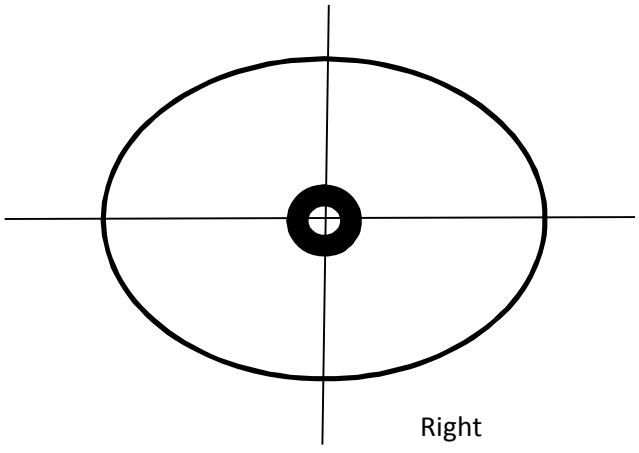
Hormone Replacement □ Yes □No Type_____

Herbal Supplements □ Yes □No Type_____

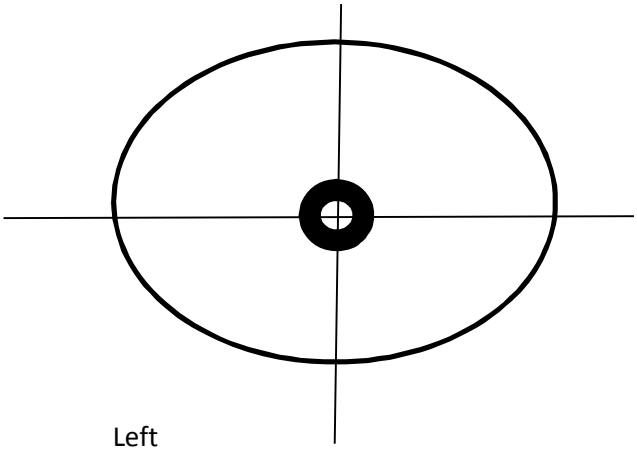
BREAST COMPLAINTS

Lump Found	□ Yes □No Date_____ Lump found by □ Self □Physician
	Bilateral_____ Right_____ Left_____
	□Hard □ Soft □ Painful □ Changes with Cycle □Mobile
Abnormal Mammogram	□ Yes □No Bilateral_____ Right_____ Left_____
	Previous abnormal mammograms □ Yes □No
Nipple Discharge	□ Yes □No Bilateral_____ Right_____ Left_____
	□ Bloody □ Milky □ Clear
Nipple Retraction	□ Yes □No Bilateral_____ Right_____ Left_____
Nipple Thickening	□ Yes □No Bilateral_____ Right_____ Left_____
Breast Asymmetry	□ Yes □No Bilateral_____ Right_____ Left_____
Breast Skin Changes	□ Yes □No Bilateral_____ Right_____ Left_____

Place an (X) on the area of concern



Right



Left