

PATIENT INFORMATION

Breast Care Unit

Female and Male Questionnaire

Please complete this questionnaire before you attend and bring it to your appointment. This questionnaire is to help us best treat your problems with your background information. For examination purposes, it would be helpful if you could wear clothing that is quick and easy for you to undress/dress on your upper body. Thank you.

Female Questionnaire

Personal Details

Full Name: _____ Title: _____ Age: _____

Weight: _____ BMI: _____ Bra Size: _____ Do you live alone: _____

Please give details of your job: _____

Your Breast Problem

Please tick the box which relates to your current breast problems.

	RIGHT	LEFT		RIGHT	LEFT
Pain and Lump			Deformity		
Lump Only			Pain Before Periods		
Pain Only			Skin Changes		
Nipple Eczema			Abscess		
Nipple Discharge			Nipple Withdrawn		
Tick if it was blood stained					

Other Symptoms:

Past History:

Please tick relevant box and comment where necessary

Have you had a breast problem in the past?

Yes No

If YES, what was it: _____

Have you had a previous diagnosis of breast cancer?

Yes No

If YES, please give details: _____

Surgery type (circle as appropriate)

Breast conserving surgery / Breast reduction type surgery / Chest wall perforator flap / Mastectomy / Wide local excision / Mastectomy and Reconstruction.

Have you had breast surgery for a previous problem or for cosmetic purposes?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Have you had radiotherapy?

Have you had chemotherapy?

Have you had immunotherapy?

Have you had hormone treatment?

Have you had a mammogram in the past?

Month and year of last mammogram: _____

Where did you have your last mammogram: _____

Do you have:

YES NO

YES NO

YES NO

High Blood Pressure

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Diabetes

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Altered immune system

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Heart Problems

Asthma

Breathing Problems

Arthritis

Other:

Do you smoke?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If YES, how many per day? _____

Are you an ex-smoker?

If YES, how many years? _____

Do you use nicotine vapes?

How much alcohol do you drink per week? _____

Family History:

Do you have any Jewish ancestry? YES NO

Has any family member had Breast / Ovarian / Prostate / Pancreatic cancer? YES NO

If YES, who:

Relationship to you	Which cancer Breast / Ovarian / Prostate / Pancreatic	Age at time of diagnosis	Current Age / Age at death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any family members with breast or ovarian cancer had any genetic testing? YES NO

If you are unclear about how to answer this section, please discuss with a member of staff when you attend clinic.

Hormone Use:

Have you ever been on the combined oral contraceptive pill? YES NO

If YES, how many years?

Are you currently using any of the following forms of hormonal contraception? (circle as appropriate)

Combined Pill / Progesterone only pill (mini pill) / IUD (Mirena/Levosert/Kyleena/Jaydess/Benilexa) / Implant / Contraceptive injection / other

Have you ever taken Hormone Replacement Therapy? YES NO

If YES, please state dose:	Combined Patch	_____
Estrogen pills	Oestrogen Only Patch	_____
Utrogestan	Oestrogen Gel	_____
Mirena Coil	Oestrogen Spray	_____

Periods:

Have you had a hysterectomy?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If YES, were your ovaries removed?

Date of your last period: _____

If your periods stopped naturally – how old were you? _____

Tablets and Medicines:

Are you taking any medicine to thin the blood?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

e.g. Warfarin / Heparin injection / Oral anticoagulants such as Rivaroxaban / Clopidogrel / Aspirin?

If YES, please state dose: _____

Do you take any biologics or medicines affecting the immune system?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

If YES, please state dose: _____

Please list names of any other tablets/medicines you are taking at the moment:

Pregnancies and Breast Feeding:

If you have never been pregnant – please ignore this section.

Are you pregnant?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

No. of pregnancies (including terminations & miscarriages): _____

No. of full-term pregnancies: _____

Did you breast feed your children?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Are you breast feeding at the moment?

YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
-----	--------------------------	----	--------------------------

Male Questionnaire

Personal Details

Full Name: _____ Title: _____ Age: _____

Weight: _____ BMI: _____ Bra Size: _____ Do you live alone: _____

Please give details of your job: _____

Your Breast Problem

Please tick the box which relates to your current breast problems.

	RIGHT	LEFT		RIGHT	LEFT
Pain and Lump			Deformity		
Lump Only			Skin Changes		
Pain Only			Abscess		
Nipple Eczema			Nipple Withdrawn		
Nipple Discharge					
Tick if it was blood stained					

Other Symptoms:

Past History:

Please tick relevant box and comment where necessary

Have you had a breast problem in the past?

Yes No

If YES, what was it: _____

Have you had a previous diagnosis of breast cancer?

Yes No

If YES, please give details: _____

Have you had breast surgery for a previous problem or for cosmetic purposes?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Have you had prostate cancer?

Have you had radiotherapy?

Have you had chemotherapy?

Have you had immunotherapy?

Have you had a mammogram in the past?

Month and year of last mammogram: _____

Where did you have your last mammogram: _____

Do you have:

YES NO

YES NO

YES NO

High Blood Pressure

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Diabetes

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

Altered immune system

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Heart Problems

Asthma

Breathing Problems

Arthritis

Other:

Do you smoke?

YES NO

If YES, how many per day? _____

Are you an ex-smoker?

YES NO

If YES, how many years? _____

Do you use nicotine vapes?

YES NO

How much alcohol do you drink per week? _____

Family History:

Do you have any Jewish ancestry?

YES NO

Has any family member had Breast / Ovarian / Prostate / Pancreatic cancer?

YES NO

If YES, who:

Relationship to you	Which cancer Breast / Ovarian / Prostate / Pancreatic	Age at time of diagnosis	Current Age / Age at death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have any family members with breast or ovarian cancer had any genetic testing?

YES NO

If you are unclear about how to answer this section, please discuss with a member of staff when you attend clinic.

Tablets and Medicines:

Have you taken any of the following medications associated with gynaecomastia:	YES		NO	
--------------------------------------------------------------------------------	-----	--	----	--

If YES, please tick which:

Finasteride		Epilim	
Spiroinolactone		Cimetidine	
Digoxin		Omeprazole/Lansoprazole/Pantoprazole	
Phenothiazines			

Have you taken any hormone treatment?	YES		NO	
---------------------------------------	-----	--	----	--

If YES, please give details

Do you use cannabis?	YES		NO	
Do you take any product supplements?	YES		NO	
Have you taken any anabolic steroids?	YES		NO	
Are you taking any medicine to thin the blood?	YES		NO	

e.g. Warfarin / Heparin injection / Oral anticoagulants such as Rivaroxaban / Clopidogrel / Aspirin?

If YES, please state dose: _____

Do you take any biologics or medicines affecting the immune system?	YES		NO	
---------------------------------------------------------------------	-----	--	----	--

If YES, please state dose: _____

Please list names of any other tablets/medicines you are taking at the moment:

For further assistance or to receive this information in a different format, please contact the department which created this leaflet.