GEOFFREY R. KEYES, M.D.
BREAST QUESTIONNAIRE

Name: _____ Date: _____

1. What is your particular breast problem? _____

2. Does this condition run in your family? ____ Yes ____ No

   If yes, who (what relationship to you)? _____

3. What is your height? _____ Weight? _____

4. What bra size do you wear? _____ Padded/Unpadded (Circle)

5. Did you breast feed? _____ Bottle-feed? _____ Out of choice? _____

6. Did your breasts change size with pregnancy? ____ Yes ____ No

   If yes, how much (in bra size)? _____

7. Have you had any breast diseases or breast tumors? ____ Yes ____ No

   If yes, please explain. (Type, Date of Surgery, Doctor)

   _____

8. Has anyone in your family ever had any breast diseases or breast tumors? ____ Yes ____ No

   If yes, please specify. _____

9. Have you ever had any serious illnesses? ____ Yes ____ No

   If yes, please specify. _____

10. Do you have any bleeding tendencies? ____ Yes ____ No

11. Have you had discharge or bleeding from your nipples? ____ Yes ____ No

12. Have you ever noticed or been told that you have a lump in your breast? ____ Yes ____ No

13. Have you had a mammogram? ____ Yes ____ No

    If yes, please specify when. _____