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Breast Health Questionnaire

These questions have been designed to give a clear picture of your present health status and to identify any potential health problems for the future. All your answers are confidential and will only be seen by the health assessor. However, should a significant health problem be detected requiring medical investigation, you will be given a letter to take to your GP.

Name: **Date of Birth:**

Company Name: **Job Title:**

E-mail: **Hours of work per week:**

Height: **Weight:**

Personal Medical History

Please put ☑ for YES and ☒ for NO. Leave blank if unsure or not relevant.

What age were you when your periods began? ☐

Pre-Menopause Only: Are your periods regular? ☐ Approx. no. of days of cycle? ☐

Do you suffer from Pre-Menstrual Tension? ☐

Do you use a medicated form of contraception? (eg pill, injection, coil) ☐

If yes, which one? ....

How long have you been using this form of contraception? ....

Have you ***ever*** been prescribed a medicated form of contraception? ☐

If so, which one?.......................................

How long did you take this form of contraception? *(If you were prescribed a medicated form of contraception, or multiple forms intermittently, estimate the cumulative amount of time you were taking it/them)*

....

Post-Menopause Only: What age were you when your periods stopped? ☐

Do you take HRT? ☐ If so, what is your medication? ....

How long have you been on HRT? ....

Have you ***ever*** taken HRT? ☐ If so, what was your medication?.......................................

How long did you take HRT? ....

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Do you experience hot flushes? ☐ If yes, how long have you experienced them? ☐

Approximately how many hot flushes do you have during the day? ☐

Approximately how many hot flushes do you have during the night? ☐

When did you have your last cervical smear test? ☐

Have you ever had an abnormal cervical smear? ☐ If so, when? ☐

What treatment did you receive? ....

....

How many live pregnancies have you had? ☐ How many miscarriages? ☐

What age were you when you had your first child? ☐

What age were you when you had your last child? ☐

Have you ever had a Caesarian Section? ☐

Did you breast feed ? ☐

If yes, what was the longest time in months/weeks that you breast fed? ☐

Do you routinely check your breasts for lumps or abnormalities? ☐

If no, do you know how to check your breasts? ☐

Have you ever noticed a breast lump? ☐

If yes, did you seek medical advice? ☐

What was the outcome? ....

Have you ever had a Mammogram? ☐ If yes, how many? ☐

Have you ever had a Breast Thermogram? ☐ If yes, how many? ☐

Medication: **Please state the medicines you are currently taking**

Name of Medicine	Dosage	Times taken per day
....	....	....
....	....	....
....	....	....
....	....	....

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Nutritional or Herbal Supplements: Please state any you are currently taking

Name of Supplement	Dosage	Times taken per day
....	....	....
....	....	....
....	....	....
....	....	....

Smoking Status:

Do you smoke? ☐ If yes, please state Cigarettes ☐ Cigars ☐ Pipe ☐ Other ☐

How many a day? ☐ Do you intend to give up smoking soon? ☐

If you do not smoke now, have you ever smoked? ☐

If yes, please state Cigarettes ☐ Cigars ☐ Pipe ☐ Other ☐

When did you stop smoking? ☐

Alcohol Status:

One unit = ½ pint of Beer/Cider, a small glass of wine, or a pub measure of spirits

What is your average weekly consumption of alcohol in units? ☐

If <1, how many units a month? ☐ Did you regularly drink more in the past? ☐

Do you drink more than 2 units a day? Never ☐ Occasionally ☐ x1/week or more ☐ Every Day ☐

Exercise:

Do you have a regular exercise routine? ☐

Do you do at least ½ hour of brisk exercise five times a week? ☐

If not, how much exercise do you do in a week? ....

What type(s) of exercise/activity do you do? ....

Do you have a sedentary job? ☐

Do you often drive short distances rather than walk? ☐

Do you normally take the lift or escalator rather than the stairs? ☐

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Exercise continued:

Do you have a disability that prevents you from exercising? ☐

Do you find time to relax each day? ☐

Dietary History:

Do you eat at least 3 meals a day? ☐

If not, which meal(s) do you miss? ....

Do you eat at least 5 portions of fruit and vegetables a day? ☐

Do you eat meat ? ☐ Do you eat fish? ☐ Are you a Vegetarian/Vegan? ☐

Do you include roughage (high fibre foods) in your diet? ☐

Do you eat convenience/processed food and takeaways? ☐

	<1 a week	1-2 x a week	3-6 x a week	Every day
If yes, how often?	☐	☐	☐	☐

	Regularly	Occasionally	Never
Do you eat organic produce?	☐	☐	☐

Do you usually add sugar to beverages or breakfast cereals? ☐

Do you use artificial sweeteners? ☐ If so, which brand? ....

Do you consume dairy products? ☐ Do you eat margarine? ☐ If so, which brand?............

How many glasses of water do you drink a day? ☐ Do you drink tap water? ☐

Is your water fluoridated? ☐ Do you use a water filter? ☐

Do you drink caffeinated tea or coffee? ☐ No. of cups of tea ☐ Cups of coffee ☐

Do you drink fizzy drinks? ☐ How many a week? ☐ Do you drink diet versions? ☐

Chemical Exposure:

Do your toiletries contain any of the following ingredients?

Sodium Lauryl Sulphate	Sodium Laureth Sulphate	Propylene Glycol	DEA / TEA / MEA
☐	☐	☐	☐

Talc	Isopropyl	DMDM hydantoin	Imidazolidinyl urea	Aluminium	Butylated hydroxytoluene
☐	☐	☐	☐	☐	☐

Do you use air fresheners (any type)? ☐

Do you use supermarket or main brands of household cleaning products? ☐

Family History:

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Have any female members of your family been diagnosed with either of the following cancers?

Please put the approximate age of diagnosis in the box if known. If your relative died from the cancer, please write D next to their age.

Breast cancer

Mother ☐ Sister(s) ☐ Daughter(s) ☐ Paternal Grandmother ☐ Maternal Grandmother ☐

Paternal Aunt (s) ☐ Maternal Aunt (s) ☐

Ovarian cancer

Mother ☐ Sister(s) ☐ Daughter(s) ☐ Paternal Grandmother ☐ Maternal Grandmother ☐

Paternal Aunt (s) ☐ Maternal Aunt (s) ☐

Have any close members of your family been diagnosed with any other type of cancer?
Please state type of cancer.

Mother ....

Father ....

Brother(s) ....

Sister(s) ....

Grandmother(s) ....

Grandfathers(s) ....

Checklist:

Tyrer-Cuzack Breast Cancer Risk Evaluation Form ☐ Risk Score: ☐

Visual Inspection Video ☐

Manual Inspection Video ☐

Breast Health Booklet ☐

Recommendations:

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