

Instructions:

Please complete this questionnaire using a No. 2 pencil or blue or black pen.
All letters and numbers must be written in capital block style without touching the sides, as shown.

O	1	2	3	4	A	B	C	D	E
---	---	---	---	---	---	---	---	---	---

Please shade circles like this: ●

1. MAMMOGRAM HISTORY

What is the main reason for your visit today?
(Choose one)

- Routine screening
 Follow-up to routine screening exam
 Concerns about breast problems

IF CONCERNS: Who first noticed your breast problems?

- Self
 Physician or other healthcare provider
 Other

When was your last mammogram?
(Choose one)

- Within the last 12 months
 1 to 2 years ago
 3 to 4 years ago
 5 or more years ago
 Never had a mammogram before

When did a health care provider last examine your breasts?
(Choose one)

- Never
 Within the last 3 months
 Between 3 – 6 months ago
 Between 6 – 12 months ago
 Between 1 and 2 years ago
 Between 2 and 5 years ago
 Not sure

2. CORE LINKING INFORMATION (used only to avoid duplication of records)

What is your date of birth?

		/			/				
M	M		D	D		Y	Y	Y	Y

What is your social security number?

				-			-				
--	--	--	--	---	--	--	---	--	--	--	--

What is your maiden name (last name only)?

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3. HEALTH HISTORY

Have any first-degree blood relatives been diagnosed with breast cancer? (Shade all that apply)

- Mother: No Yes Not sure
 Sister: No One 2 or more Not sure
 Daughter: No One 2 or more Not sure

IF YES, were any diagnosed before age 50?

- Mother: No Yes Not sure
 Sister: No One 2 or more Not sure
 Daughter: No One 2 or more Not sure

Have your menstrual periods stopped permanently?
(Choose one)

- No
 Yes, natural menopause
 Yes, surgical procedure (female organs removed)
 Yes, other reason
 Not sure

IF periods have stopped, age at menopause:

--	--

years old

IF NO or NOT SURE that periods have stopped, when was the first day of your last menstrual period?

		/			/				
M	M		D	D		Y	Y	Y	Y

Have you ever give birth? Yes No

IF YES: how old were you when your first child was born?

--	--

years old

How many children have you given birth to

--	--

number of children

How old were you when you had your first menstrual period? (Choose one)

- 12 or younger
 13
 14
 15 or older
 Not sure
 Never started my period

Have you ever had an ovary removed?
(Choose one)

- No ovary removed
 Yes, one ovary removed
 Yes, both ovaries
 Yes, but don't know if one or both
 Don't know

3. HEALTH HISTORY (Contd.)

Have you or a blood relative ever been diagnosed with ovarian cancer?

- No
 Self
 Mother, sister, daughter
 Other relative
 Not Sure

4. PERSONAL HISTORY

Are you of Hispanic, Spanish, or Latino origin?

- No Yes

What is your racial or ethnic background?
(Shade all that apply)

- White
 Black or African American
 Asian
 Native Hawaiian or other Pacific Islander
 American Indian or Alaska Native
 Other, describe: _____

What is the highest level of education you have completed?
(Choose one)

- Less than high school graduate
 High school graduate or GED
 Some college or technical school
 College or post-college graduate

What is your current height?
(to the nearest inch)

feet	inches		

for example 5 ft 6½ ins. = 5 0 7

What is your current weight?

Pounds		

for example 98 lbs. = 0 9 8

What did you usually weigh
(when not pregnant) when you were
between 18 and 20 years old?

Pounds		

What kind of health care coverage do you have?
(Shade all that apply)

- Medicare
 Medicaid
 Private insurance plan (with Blue Cross, AETNA, etc.)
 Managed care plan (with Blue Choice or other HMO/PPO)
 Other, describe: _____
 Not sure
 I have no coverage

What is your current marital status? (Choose one)

- Single Divorced
 Married Widowed
 Separated Living as married

4. PERSONAL HISTORY (Contd.)

Where were you born?

- USA Other: _____

If born in USA, in which state were you born?

--	--

State

(for example: NH, VT, MA, ME, etc.)

Thank You!