1. Have you had any of the following breast changes in the last 3 months? (check all that apply)

- Lump
- Nipple discharge
- Pain
- Other, describe: __________________________  □ No changes

- Both
- Left
- Right

2. When was your last mammogram?
□ Date: __ __ / __ __ __ __ (month/year)
□ I never had a mammogram

3. When did a health care provider last examine your breasts?
□ Date: __ __ / __ __ __ __ (month/year)
□ Within the last 3 months
□ 4 months to 1 year ago
□ More than 1 year ago

4. Have you ever been diagnosed with breast cancer?
□ No  □ Yes

If YES, please answer the following questions:

- Which breast(s)? □ Right  □ Left  □ Both
- At what age were you first diagnosed? □ __ __ __ __ years old

OR: Date of diagnosis: __ __ / __ __ __ __ (month/year)
At what age were you first diagnosed? □ __ __ __ __ years old

5. Have you had any of the following breast procedures?
□ I have not had any of the above procedures

- Fine needle or cyst aspiration  □ Left  □ Right  □ Both
- Biopsy  □ Left  □ Right  □ Both
- Lumpectomy (for breast cancer)  □ Left  □ Right  □ Both
- Mastectomy  □ Left  □ Right  □ Both
- Radiation therapy  □ Left  □ Right  □ Both
- Breast reconstruction  □ Left  □ Right  □ Both
- Breast reduction  □ Left  □ Right  □ Both
- Breast implants (still present)  □ Left  □ Right  □ Both

6. Have any blood relatives been diagnosed with breast cancer?

- 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

7. Have you or a blood relative ever been diagnosed with ovarian cancer?
□ No
□ Self
□ M other, sister, or daughter
□ Other relative
□ Not sure

8. How old were you when you had your first period?
□ < 12
□ 12
□ 13
□ 14
□ 15 or older
□ Not sure
□ Never started my period

9. Are you currently using Hormone Replacement Therapy (HRT) including pills, patches or cream?
□ No  □ Yes

If you are currently using HRT, please check the type:

- Estrogen only (such as estradiol, Premarin, Estrace)
- Progesterone only (such as medroxyprogesterone acetate, Provera)
- Estrogen and Progesterone combination (such as Prempro, CombiPatch, Aktivella, FemHRT)
- Do not know the type

How long have you used HRT?
□ For less than 5 years in a row
□ Five or more years in a row

10. Have your menstrual periods stopped permanently?
□ No  □ Yes

If YES, please check type:

- Birth control hormones (pills, patches, implants)
- Natural hormones for the relief of menopausal symptoms (such as non prescription herbs like black cohosh and other supplements)

11. Have you had an ovary removed?
□ No  □ Yes

If YES, please check type:

- Exemestane/Aromasin
- Letrozole/Femara
- Tamoxifen (also called Nolvadex, Istubal, Valodex)
- Raloxifene (also called Evista)
- Aromatase Inhibitors
- Natural hormones for the relief of menopausal symptoms (such as non prescription herbs like black cohosh and other supplements)

12. Have you given birth?
□ No  □ Yes

If YES: How old were you when your first child was born? □ __ __ years old

13. What is your current height? □ feet □ inches

14. What is your current weight? □ __ __ pounds

Today’s date: __ __/ __ __/ __ __ (month/day/year)
Date of birth: __ __/ __ __/ __ __ (month/day/year)
15. Are you of Hispanic, Spanish, or Latino origin?
   □ No □ Yes

16. What is your racial or ethnic background?
   (check all that apply)
   □ White
   □ Black or African American
   □ Asian
   □ Native Hawaiian or other Pacific Islander
   □ American Indian or Alaska Native
   □ Other, describe: _________________________

17. What is the highest level of education you have completed?
   (check one)
   □ Less than high school graduate
   □ High school graduate or GED
   □ Some college or technical school
   □ College or post-college graduate

18. What kind of healthcare coverage do you have?
   (check all that apply)
   □ Medicare □ Medicaid □ Private insurance
   □ Managed care (such as HMO or PPO)
   □ Other, describe: _________________________
   □ Not sure
   □ I have no coverage

Thank you for taking time to complete this questionnaire.