

Bay Surgical Specialists, PA

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BREAST QUESTIONNAIRE

1. Family history of breast cancer? Yes No
If yes, who? _____
Age at diagnosis of cancer: _____
2. Personal history of breast cancer? Yes No
3. History of ovarian cancer? Yes No
Personal or family history? (circle one)
4. Age when you started menses: _____
Still menstruating? Yes No
Hysterectomy? Yes No
Ovaries removed? Yes No
5. Are you or have you taken hormone replacement? Yes No
6. If yes, are you still taking them? Yes No
For how many years? _____
7. Number of pregnancies: _____
Number of children: _____
Your age at the time of each birth: _____
8. Any breast biopsies? Yes No
Which breast? (circle one) Right Left Both
When was biopsy done? _____

PATIENT NAME: _____

DATE: _____

REVIEWED BY: _____

DATE: _____

Physician/Provider