POTOMAC RADIATION ONCOLOGY CENTER
A SERVICE OF INOVA AND SENTARA HEALTHCARE

Breast Cancer Questionnaire

Patient's Name: _____ **Today's Date:** _____

1. Please give the name of the doctor who has referred you to Potomac Radiation Oncology Center : _____

2. How old were you when you had your first period? _____

3. How many pregnancies have you had, if any? _____
   How may live births? _____

4. How old were you at the birth of your first child? _____

5. Did you breast feed your children? _____

6. Have you ever taken birth control (pills or Depo Provera shots?) No _____ If yes, for how long? _____

7. Have you gone through menopause? No _____ If yes, at what age? _____
   _____

8. Are you taking, or have taken hormone replacement? No _____ If yes, what have you taken and for how long? _____

9. Do you perform breast self-examinations? Yes _____ No _____

10. Do you have any relatives with breast cancer? No _____ If yes, how are they related to you and how old were they when diagnosed, and what treatment was performed?
    _____
    _____
    _____

11. Do you have any skin conditions or collagen vascular disorders such as lupus or scleroderma? _____

12. Have you ever had prior radiation treatments? If so, please describe and give dates of treatment. _____
    _____
    _____