【 Breast Surgery Questionnaire 】

Date of examination：year / month / day /		
		Birthday year /month /day
Name		
〒 －	【Adress】	
Phone number ( )		
Subjective symptoms ☐no yes（☐lump ☐pain ☐nipple discharge ☐other（ ）		
Have you been told the breast cancer (suspicion) in another hospital? ☐yes ☐no		
Have you already treated breast cancer in another hospital? ☐yes ☐no		
Please give details of the past circumstances.		

Medical history	☐none	☐ yes (hypertension • asthma • diabetes • osteoporosis)	
		☐allergy（ ）	
Surgical history	☐none	☐yes age /type of surgery（ ）	
Smoking	☐no	☐yes Duration years	
Drinking	☐no	☐yes ( )mL/day	
Other	〔age	〔age	〕
	〔age	〔age	〕
Gynecological history	☐married ☐not married ☐bereavement		
Menstruation	☐well ☐irregularities ☐menopause（age ）☐population menopause（age ）		
Pregnancy • Childbirth	pregnancy：	birth：	☐pregnant： months ☐possibility
Gynecological illness	☐none	☐yes ☐Uterine fibroids〔surgery ☐no ☐yes surgical type： 〕 ☐ Endometriosis ☐ Ovarian cyst 〔surgery ☐no ☐yes surgical type： 〕 ☐ other（ ）〔surgery ☐no ☐yes surgical type： 〕	
Breastfeeding history	☐none ☐breastfeeding ☐yes		
Fertility treatment history	☐none ☐yes		
Hormone replacement therapy	☐none ☐yes		
Breast Augmentation	☐no ☐yes ※Fill in the injection type.		
Pacemaker	☐none ☐yes		

Internal medicine • Supplement

☐none ☐yes（ ）

Family history	Relatives(paternal maternal cousin)
Breast cancer Ovarian cancer	
brothers and sisters/children：	
mother，maternal blood relationship：	
father，paternal blood relationship：	
Other cancer	

How did you know about this clinic?

☐Website ☐Introduction of acqaintance( )☐Introduction from other hospitals ☐SNS ☐Other( )

Thank you for filling out a questionnaire form.We use this information for accurate diagnosis.