JIYUGAOKA MIKI BREAST CLINIC
自由が丘 みきブレストクリニック

Breast Clinic Questionnaire

Please fill in this form before consultation as far as you can.

Address 〒 TEL :

Name M・F

Date of Birth Age

- Menopause ( ) years old (Artificial ・ Natural)
- Pregnancy ☐No ☐Yes ( )times ☐Pregnant
- Have you ever breast-fed? ☐No ☐Yes ( ) years ago ☐Currently breast-feeding
- Have you had breast augmentation? ☐No ☐Yes (☐ Implant ☐others)

I. Reason for visit
☐Health screening ☐Have symptom ⇒ Go #II

II. Please answer if you have symptom
Do you have pain? No / Yes (Left・Right)
Do you have lump? No / Yes (Left・Right)
Do you have secretions from nipple? No / Yes (Left・Right)
Have you had breast abnormality?
No / Yes If yes, please describe( )

III. Do you family or relatives have breast cancer? No / Yes (Who? What age?)

IV. Medical history
If you have any illness which is under treatment or regular follow-up, please describe.
( )

V. Medication history
Are you currently taking medicine? ☐No ☐Yes, Name of the medicine( )

Thank you for answering.
If you have any question, please feel free to ask us.