SYMPTOM AND HISTORY FORM

Client reference:

BreastScreen TASMANIA

If you need more tests are you available for the next four weeks? ☐ Yes ☐ No

Surname: Given name:

Date of birth: / / Email:

1. BREAST SYMPTOM STATUS

Do you have any of the following breast symptoms: No symptoms ☐ = Go to section 2.

If yes, please ☑ tick which side(s):

a. New lump or lumpiness – not investigated	☐ Left	☐ Right
b. Lump or lumpiness – previously investigated	☐ Left	☐ Right
c. Skin dimpling and/or redness	☐ Left	☐ Right
d. Nipple discharge without squeezing – clear	☐ Left	☐ Right
e. Nipple discharge without squeezing – blood stained	☐ Left	☐ Right
f. Nipple changes – crusting, inversion, ulcer or redness	☐ Left	☐ Right
g. Change in size and shape of breast	☐ Left	☐ Right
h. Unusual pain that doesn't go away	☐ Left	☐ Right

2. HISTORY OF BREAST/OVARIAN CANCER

Have you had breast cancer? ☐ Yes ☐ No **Year of diagnosis**

If yes, please ☑ tick which side(s): ☐ Left ☐ Right

Have you had ovarian cancer? ☐ Yes ☐ No

3. FAMILY HISTORY OF BREAST/OVARIAN CANCER

Has anyone in your family had breast/ovarian cancer? ☐ Yes ☐ No ☐ Unknown

Relationship to you	Mother's side	Father's side	Age at diagnosis	One breast	Both breasts	Ovarian	Unknown
	☐	☐		☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐
	☐	☐		☐	☐	☐	☐

4. MEDICAL HISTORY

Have you had breast surgery? ☐ Yes ☐ No

☐ Left breast ☐ Reduction ☐ Implant ☐ Other

☐ Right breast ☐ Reduction ☐ Implant ☐ Other

Have you been on hormone replacement therapy (HRT) in the last six months? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have a pacemaker/implantable device? ☐ Yes ☐ No

OFFICE USE ONLY:

Annual Screener ☐ Name SSO/RAD:

Date: / /

Tasmanian Government