OSPIDÉAL SAN SÉAMAS
ST JAMES'S HOSPITAL

Please complete this questionnaire BEFORE you attend your appointment

Patient Questionnaire SECTION 1

First Name _____ Date of Birth ____/____/____

Surname _____

Maiden Name _____

Have you ever attended St James's Hospital before? YES/ NO
If YES; please tick did you attend the
SYMPTOMATIC CLINIC ☐ FAMILY HISTORY CLINIC ☐

Telephone No _____ GP Name _____

Mobile No _____ Address _____

Address _____

_____

_____

_____

_____ GP Telephone _____

Emergency Contact _____

N.O.K -Name _____ Do you have Health Insurance Yes / No

Relationship _____ Insurance Name _____

Address _____

_____ Policy No _____

_____ Plan _____

_____

N.O.K -Phone _____ Do you have a Medical Card Yes / No

Your Religion _____ Card No _____

Your Marital Status _____ Expiry date _____

Your Occupation _____

Patient Questionnaire SECTION 2

Please complete this questionnaire BEFORE you attend your appointment

Please ensure you answer ALL questions

Patient Name: _____ **Hospital Number:** _____

If the answer is not applicable to you, please mark the box **N/A**.

Weight **(KG)**	Date of your last period
Height **(CM)**	Age at your first period
Bra Size	Age at onset of menopause
Occupation	Number of full-term pregnancies
	Age when your first child was born

How often do you exercise each week?

Once	**Twice**	**More**	**Never**

For the next questions please tick **Yes** or **No** column as appropriate **and** provide brief details.

DO YOU HAVE A HISTORY of any of the following?

	Yes	**No**	**Location/ Dates/ Details**
Hysterectomy (womb removed)			
Oophorectomy (ovary/ both ovaries removed)			
Cardiovascular disease			
Angina / Ischemic Heart disease			
Stroke / Cerebrovascular disease			
High blood pressure			
Diabetes			
High Cholesterol			
Clots / Thrombosis			
Asthma			
Chronic Obstructive Airways Disease			
Psychiatric illness			
Any other illness or operation			

Hormonal history

	Yes	**No**	**Now**	**Comment - Duration/ Type/ Cycles**
Have you ever taken a contraceptive pill?				
Other contraceptive hormone				
Fertility treatment/ IVF				
HRT				

Hormonal history continued:

	Yes	**No**	**Now**	**Comment**
Do you think you may be in the menopause now?				

Are you pregnant now?				
Are you breastfeeding now?				
Did you ever breastfeed? For how long?				

Breast imaging and Investigations

	Yes	No	Location/ Dates/ Details
Have you had a breast complaint before?			
Have you ever had a mammogram? Where? Hospital or Breast Check?			
Have you ever had a breast Ultrasound?			
Have you ever had a breast MRI scan?			
Have you ever had a breast biopsy?			
Have you ever had breast surgery?			
Have you ever had breast cancer?			
If yes, did you have chemotherapy?			
If yes, did you have radiotherapy?			

Medication and Social History

	Yes	No	Location/ Dates/ Details
Are you currently taking medication?			
PLEASE LIST MEDICATIONS			
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Do you have any allergies?			
Do you have hay fever?			
Do you have any implants?			
Or any metal in your body? i.e., piercings			
Do you smoke?			
Do you drink alcohol? How many units a week? (See below for details)			
An alcoholic unit is: ½ pint / glass beer, lager, stout or cider / Single measure of spirits (whiskey, gin, vodka, rum) Single glass of wine sherry or port/ Pre mixed drinks (Breezer, Coolers etc)			

Do you have a FAMILY HISTORY of any of the following?

	Yes	No	Relationship **and** age when diagnosed
Breast Cancer			
Ovarian Cancer			
Prostate Cancer			
Other Cancer			
If YES to FAMILY HISTORY of Breast Cancer, please state if you have attended St James Hospital Breast Family History Clinic: YES or NO			