

Illinois Breast and Cervical Cancer Program  
**HEALTH ASSESSMENT**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**BREAST HEALTH QUESTIONS**

**YES NO**

- 1. Do you perform a monthly breast self exam?
- 2. Have you noticed a lump in your breasts?
- 3. Have you noticed any breast tenderness or pain?
- 4. Have you noticed any discharge from your nipples?
- 5. Have you noticed any other symptoms related to your breasts?  
If yes, explain: \_\_\_\_\_
- 6. Have you ever had a clinical breast exam done by a doctor or nurse?
- 7. If yes, date of last exam: \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- 8. Have you ever had a mammogram?
- 9. If yes, date of last two mammograms: \_\_\_\_/\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- 10. Have you ever had breast cancer?
- 11. Has your mother, sister or daughter had breast cancer? If no, go to question 14.
- 12. If yes, who? \_\_\_\_\_
- 13. If yes, at what age? \_\_\_\_\_ years old
- 14. Do you have a breast implant or implants?
- 15. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?

**CERVICAL HEALTH QUESTIONS**

**YES NO**

- 16. Have you ever had a Pap test?
- 17. If yes, date of last two Pap tests: \_\_\_\_/\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- 18. What was the date of your last menstrual period? \_\_\_\_/\_\_\_\_/\_\_\_\_\_
- 19. Have you had a hysterectomy?
- 20. Was your hysterectomy due to a past history of cervical disease or cervical cancer?