The Raine Study Gen2_27 year follow up

TiBS Study

Date.....
IDNumber.....
Name.....
Date of Birth.....

Reproductive History

1. **How old were you when you had your first period?** **…….**
2. **Have you ever had a pregnancy?**
   - ☐ No, *Please go to Q4*
   - ☐ Don't know, *Please go to Q4*
   - ☐ Yes, *Please go to Q2a*

2a. If Yes, How many pregnancies have you had? …….

2b. Are you currently pregnant? No ☐ yes ☐ How many months? …….

2c. Are you currently breastfeeding No ☐ yes ☐

3. Information on pregnancy, birth and baby

First pregnancy	**Date of birth or end of pregnancy**	**Gestation of pregnancy (weeks)**
O Livebirth- single		
O Livebirth - twins		
O Livebirth - triplets		
O Stillbirth		
O Miscarriage		
O Ectopic		
O Termination		
O Don't know		
Sex of baby(ies) ☐Male ☐Female	**Did you breast feed?** ☐No ☐Yes	**For how long did you breast feed? (number of weeks or months)**

Second pregnancy

Outcome	Date of birth or end of pregnancy	Gestation of pregnancy (weeks)
O Livebirth - single		
O Livebirth - twins		
O Livebirth - triplets		
O Stillbirth		
O Miscarriage		
O Ectopic		
O Termination		
O Don't know		
Sex of baby(ies) ☐ Male ☐ Female	**Did you breast feed?** ☐ No ☐ Yes	**For how long did you breast feed (number of weeks or months)**

Third pregnancy

Outcome	Date of birth or end of pregnancy	Gestation of pregnancy (weeks)
O Livebirth - single		
O Livebirth - twins		
O Livebirth - triplets		
O Stillbirth		
O Miscarriage		
O Ectopic		
O Termination		
O Don't know		
Sex of baby(ies) ☐ Male ☐ Female	**Did you breast feed** ☐ No ☐ Yes	**For how long did you breast feed (number of weeks or months)**

4. Contraceptive Use and Menstruation

Do you currently use contraception?

- O No *(Please go to Q5)*
- O Yes

  What kind of contraception do you use? (tick all that apply)

  - O Male condoms
  - O Female condoms
  - O Diaphragm
  - O Oral contraceptive pill (please give the name: _____)
  - O Coil
  - O Injection (Depo Provera)
  - O Implant (e.g. Implanonon)
  - O Inter uterine device (IUD, Ring)
  - O Sterilisation (vasectomy, tubal ligation)
  - O Contraceptive vaginal ring
  - O Other (please specify) ……..

5. What was the date of your last menstrual period (first day) ___ /___ /_____

6. If your periods have stopped for more than 2 months, why did they stop? *(select one answer only)*

- O Periods have not stopped
- O Irregular periods (no contraception use)
- O Contraception use
- O Natural menopause (that is, periods stopped by themselves)
- O Hysterectomy (uterus or womb removed)
- O Both ovaries removed
- O Radiation or chemotherapy
- O Pregnant/breast feeding
- O Serious illness (eg. Anorexia)
- O Strenuous exercise
- O Don't Know
- O Other, specify reason_____

7. Medical and Surgical History

	No	Yes	Age
1. Have you ever had breast reduction surgery?	☐	☐	
2. Have you ever had breast enlargement surgery?	☐	☐	
3. Has a doctor ever told you that you had benign breast disease, such as a non-cancerous cyst or a breast lump that was NOT removed?	☐	☐	
4. Have you ever had a benign breast lump (s) REMOVED such as a non-cancerous cyst? If yes, which breast(s) ☐Left ☐Right ☐Don't know	☐ ☐	☐ ☐	
5. Have you ever had a breast lump(s) that was diagnosed as an in-situ cancer such as DCIS or ductal carcinoma in situ? If yes, which breast(s) ☐Left ☐Right ☐Don't know	☐ ☐	☐ ☐	
6. Have you ever been diagnosed with malignant breast cancer? If yes, which breast(s) ☐Left ☐Right ☐Don't know	☐ ☐	☐ ☐	

8. Family History

Have any of your relatives ever had breast or ovarian cancer?

- O No
- O Yes, *please indicate below*

Relationship	Breast cancer (tick all that apply)	Ovarian cancer (tick all that apply)	Approximate age at diagnosis
Mother			
Sister 1			
Sister 2			
Sister 3			
Maternal Aunt 1			
Maternal Aunt 2			
Paternal Aunt 1			
Paternal Aunt 2			
Maternal Grandmother			
Paternal Grandmother			

TiBS ASSESSMENT

1. Areola Size (Diameter)

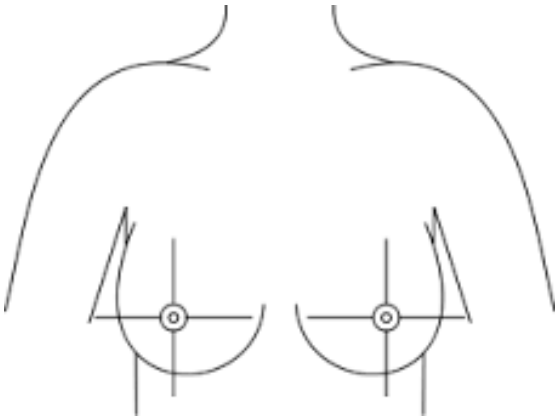
Right: _____ cm Left: _____cm

2. Scars ☐No ☐Yes

Tattoos ☐No ☐Yes

Aproximate size: Width _____mm Length _____mm

Mark on diagram below with and "X" the side and location (quadrant):



3. Piercings **Right** ☐No ☐Yes **Left** ☐No ☐Yes

4. Breast Skin Colour

Please circle closest skin colour: