Unique ID: ..... Date: .....

42. Menstrual history: LMP: _____ Number of days in cycle: _____ ☐ Regular ☐ Irregular

43. Number of pregnancies: Term: _____ Abortions: _____ (abortions after 6 months = term)

44. Age of 1st child: _____ yrs 45. Age of last child: _____ yrs

46. Twice birth in a year? ☐ Yes ☐ No (Twins to be counted as one)

47. Breast feeding: ☐ Yes ☐ No ☐ Right ☐ Left ☐ Both

Total duration: _____ months

Child 1: _____ months Child 2: _____ months Child 3: _____ months Child 4: _____ months

48. Birth control pills: ☐ Yes ☐ No Duration: _____

F. Medical History:

Symptoms	Right breast	Left breast	Duration in month(s)
49. Pain/tenderness	☐	☐	
50. Lump	☐	☐	NOSE →
51. Nipple discharge	☐	☐	
52. Nipple retraction	☐	☐	
53. Dimpling	☐	☐	
54. Discolouration	☐	☐	
55. Ulceration	☐	☐	
56. Eczema	☐	☐	

57. Detected by ☐ Self ☐ Physician ☐ Screening **Camp ID:** _____

58. Metastatic symptoms ☐ None ☐ Bone pain ☐ Cough ☐ Jaundice ☐ Headache ☐ Weight loss

59. Previous biopsy/aspiration ☐ Yes ☐ No

G. Lifestyle:

60. Diet ☐ Vegetarian ☐ Non-vegetarian ☑ Ovo-vegetarian

61. Alcohol consumption ☑ Yes ☐ No

If yes, consumption from what age? _____ Quantity: _____ /week

Duration of practice: _____ Comments: _____

62. Tobacco ☐ Smoking ☐ Chewing ☒ No

If yes, consumption from what age? _____ Quantity: _____ /week

Duration of practice: _____ Comments: _____

63. Other deleterious habits: _____

64. Nutritional supplements ☐ Yes ☐ No

Name/type of supplement: _____ (e.g., calcium, iron, vitamins)

Duration of usage: _____ Quantity: _____ /day