Symptoms Right breast Left breast Duration in month(s) 49. Pain/tenderness	Unique ID:					Date:			
46. Twice birth in a year?									
47. Breast feeding:		44.	Age of 1st child: yrs		45. Age of last	child: yrs			
Total duration:		46.	Twice birth in a year?	es 🛮 No	(Twins to be cour	ited as one)			
Child 1:months Child 2:months Child 3:months Child 4:months 48. Birth control pills:		47.	Breast feeding:	es 🛮 No	Right	Left	☐ Both		
### As. Birth control pills:			Total duration: month:	S					
### As. Birth control pills:					s Child 3:	months	Child 4:	months	
Symptoms		48.							
Symptoms	F.	Med	dical History:						
50. Lump				Right breast I	Left breast	Duration in	n month(s)		
50. Lump		49.				15 da	48 ago +	Levee.	
52. Nipple retraction		50.	Lump				V V	0	
53. Dimpling 54. Discolouration 55. Ulceration 56. Eczema 57. Detected by 58. Metastatic symptoms None Bone pain Cough Headache Weight loss 59. Previous biopsy/aspiration Yes No C. Lifestyle: 60. Diet Vegetarian Non-vegetarian Ovo-vegetarian 61. Alcohol consumption If yes, consumption from what age? Duration of practice: Comments: 62. Tobacco Smoking Chewing No If yes, consumption from what age? Quantity: Veek Duration of practice: Comments: 63. Other deleterious habits: 64. Nutritional supplements Yes No No (e.g., calcium, iron, vitamins)		51.	Nipple discharge						
54. Discolouration		52.	Nipple retraction						
55. Ulceration		53.	Dimpling						
56. Eczema		54.	Discolouration						
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: //week Duration of practice: Comments: //week Duration of practice: No Mame/type of supplements Yes No Name/type of supplement: Yes No Name/type of supplement: (e.g., calcium, iron, vitamins)		55.	Ulceration						
Sa. Metastatic symptoms		56.	Eczema						
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: //week Duration of practice: No If yes, consumption from what age? Quantity: //week Duration of practice: No Mame/type of supplements Yes No Name/type of supplement: (e.g., calcium, iron, vitamins)		57.	Detected by	Self	Physician	Scree	ning Camp ID:		
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: //week Duration of practice: Comments: //week Duration of practice: No 63. Other deleterious habits: //week 64. Nutritional supplements Yes No Name/type of supplement: Yes No Name/type of supplement: (e.g., calcium, iron, vitamins)		58.	Metastatic symptoms	None	Bone pain	Cough	1		
G. Lifestyle: 60. Diet				Jaundice	Headache	Weigh	it loss		
Ovo-vegetarian Ovo-		59.	Previous biopsy/aspiration	Yes	☐ No				
Ovo-vegetarian Ovo-	G.	Life	estyle:						
61. Alcohol consumption		60.	Diet	Vegetaria	n Non-vegeta	arian 🗌 (Ovo-vegetarian		
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: Nutritional supplements Yes No Name/type of supplement: (e.g., calcium, iron, vitamins)			If yes, consumption from what age?		Q	Quantity:/week			
If yes, consumption from what age? Quantity:/week Duration of practice: Comments: 63. Other deleterious habits: 64. Nutritional supplements			Duration of practice:		С	omments:			
Duration of practice: Comments: 63. Other deleterious habits: 64. Nutritional supplements		62.	Tobacco	☐ Smoking	Chewing	☐ No			
63. Other deleterious habits: 64. Nutritional supplements Yes Name/type of supplement: (e.g., calcium, iron, vitamins)			If yes, consumption from what	age?	Q	uantity:	/week		
64. Nutritional supplements			Duration of practice:		C	omments:			
Name/type of supplement: (e.g., calcium, iron, vitamins)		63.	Other deleterious habits:			en granden bestign:			
		64.	Nutritional supplements	Yes	☐ No				
Duration of usage:/day			Name/type of supplement:			(e.g., cal	cium, iron, vitan	nins)	
			Duration of usage:		C	luantity:	/day		

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