

Unique ID:

Date:

42. Menstrual history: LMP: 18 Jan 17 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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>15 days ago + fever</u>
50. Lump	<input type="checkbox"/>	<input type="checkbox"/>	_____
51. Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
52. Nipple retraction	<input type="checkbox"/>	<input type="checkbox"/>	_____
53. Dimpling	<input type="checkbox"/>	<input type="checkbox"/>	_____
54. Discolouration	<input type="checkbox"/>	<input type="checkbox"/>	_____
55. Ulceration	<input type="checkbox"/>	<input type="checkbox"/>	_____
56. Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
57. Detected by	<input type="checkbox"/> Self	<input type="checkbox"/> Physician	<input type="checkbox"/> Screening Camp ID: _____
58. Metastatic symptoms	<input type="checkbox"/> None	<input type="checkbox"/> Bone pain	<input type="checkbox"/> Cough
	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Headache	<input type="checkbox"/> Weight loss
59. Previous biopsy/aspiration	<input type="checkbox"/> Yes	<input type="checkbox"/> 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