

Unique ID: .....

Date: .....

42. Menstrual history: LMP: 27.01.17 Number of days in cycle: 25 ☒ Regular ☐ Irregular  
 43. Number of pregnancies: Term: NO Abortions: \_\_\_\_\_ (abortions after 6 months = term)

44. Age of 1st child: NO 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 checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	_____
50. Lump	<input checked="" type="checkbox"/>	<input checked="" 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