

Unique ID: .....

Date: .....

42. Menstrual history: LMP: 1 Feb Number of days in cycle: \_\_\_\_\_ ☒ Regular ☐ Irregular  
 43. Number of pregnancies: Term: 1 Abortions: — (abortions after 6 months = term)

44. Age of 1st child: 8 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: 24 months  
 Child 1: 24 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>3rd Dec 16</u>
50. Lump	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
51. Nipple discharge	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
52. Nipple retraction	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
53. Dimpling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
54. Discolouration	<input type="checkbox"/>	<input checked="" type="checkbox"/>	_____
55. Ulceration	<input type="checkbox"/>	<input type="checkbox"/>	_____
56. Eczema	<input type="checkbox"/>	<input type="checkbox"/>	_____
57. Detected by	<input checked="" 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 checked="" 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: — /weekDuration of practice: —

Comments: \_\_\_\_\_

62. Tobacco ☐ Smoking ☐ Chewing ☒ No

If yes, consumption from what age? —Quantity: — /weekDuration 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