**Breast Cancer Prevention**

**Questionnaire on risk factors for developing breast cancer.**

**1) Age at Diagnosis:** \_\_\_\_\_\_\_\_\_\_

**Current Age**: \_\_\_\_\_\_\_\_\_\_

**2) Weight at diagnosis:** \_\_\_\_\_\_\_\_\_\_

**Current weight:** \_\_\_\_\_\_\_\_\_\_

**Weight at puberty:** \_\_\_\_\_\_\_\_\_\_

**Weight change of 10 % or more? Yes  NO **

**3) Height:**  \_\_\_\_\_\_\_\_\_\_

**4) Level of education**:

Elementary completed  Elementary not completed 

Secondary completed  Secondary not completed 

Tertiary level 

**5) You are: Non-smoker  former smoker  smoker** 

**6) Menopausal stage**:

1. Maintains menstruation: YES  NO 
2. Has not menstruated for at least a year: YES  NO 

**In case you have stopped menstruating, please indicate**:

Age of last menstruation: \_\_\_\_\_\_\_\_\_\_

If you have taken or take hormones for menopause symptoms:

YES  NO 

In case you take hormones, please indicate name of the medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and for how long have you taken them \_\_\_\_\_\_\_\_\_\_ .

**7) Number of sons/daughters**: \_\_\_\_\_\_\_\_\_\_ .

**8) Age at birth of your first son/daughter**: \_\_\_\_\_\_\_\_\_\_ 

**9) Lactation for at least 6 months:** YES  NO 

**10) Indicate if you have any relatives treated for breast cancer:** YES   NO 

**In case you have, please indicate the relationship level and age at diagnosis**:

Mother: YES   NO  AGE at DIAGNOSIS\_\_\_\_\_\_\_\_

Father: YES   NO  AGE at DIAGNOSIS \_\_\_\_\_\_\_\_

Sister: YES   NO  AGE at DIAGNOSIS \_\_\_\_\_\_\_\_

**If you marked YES, please indicate**:

Number of sisters with breast cancer\_\_\_\_\_\_

Age/ages at diagnosis\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Brother: NO  YES  AGE at DIAGNOSIS \_\_\_\_\_\_\_\_

Paternal aunt: NO   YES  AGE at DIAGNOSIS \_\_\_\_\_\_\_\_

**If you marked YES, please indicate**:

Number of paternal aunts with breast cancer \_\_\_\_\_\_

Age/ages at diagnosis \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Maternal aunt: NO   YES 

**If you marked YES, please indicate**:

Number of maternal aunts with breast cancer \_\_\_\_\_\_

Age/ages at diagnosis \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Maternal Grandmother: NO   YES 

Paternal Grandmother: NO  YES 

Maternal first cousin: NO    YES 

**If you marked YES, please indicate**:

Number of cousins with breast cancer \_\_\_\_\_\_

Age/ages at diagnosis \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Paternal first cousin: NO    YES 

**If you marked YES, please indicate**:

Number of cousins with breast cancer \_\_\_\_\_\_

Age/ages at diagnosis \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**11) Physical activity.**

**Please indicate if you perform any of the following activities:**

a)  Walk for at least 30 minutes 3 times a week: YES  NO 

b)  Other type of exercise: YES  NO 

¿Which one? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Once a week 
2. Twice a week 
3. More than twice a week  

**12) Please indicated if you consume any of the following beverages**:

Wine 

Beer 

Vermouth 

Liquor 

Whisky 

Another alcoholic beverage 

**In case you consume alcoholic beverages, please indicate quantity and frequency out of the following options:**

At least one cup a day:   YES  NO 

At least one cup a few days of the week (not every day):

- three or less than three per week 

- More than three times per week  

**13) In relationship to early diagnosis**:

a)  Performed mammography at least every 2 years before diagnosis of the disease:

YES  NO 

b)  Performed medical breast examination at least every 2 years before diagnosis of the disease

YES  NO 

**14) In relationship to diagnosis of benign breast alterations:**

a)  Before diagnosing breast cancer, your physician indicated you had “dense breasts” or “fibrocystic breasts” according to the mammography.

YES  NO 

b)  Before diagnosing breast cancer, you had one or more breast biopsies performed that resulted in a pathology that increased the risk of breast cancer:

YES  NO 

**15) How were you diagnosed with breast cancer?**

Breast self-examination YES  NO 

Mammography screening YES  NO 

Physician´s finding YES  NO 