Breast Pain Questionnaire

Name: Ethnicity (optional): Birthdate:

Have you ever been diagnosed with breast cancer? ____Yes ____No

Post-menopausal? ____Yes ____No

1. Have you experienced breast pain within the **last three months**? ___Yes ___No

If yes, please continue to fill out the rest of this survey.

2. **What does your breast pain feel like?**

Please check one of the four categories (none, mild, moderate, or severe) for each descriptor.

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Sharp				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

3. What is the **amount** of your overall breast pain? Write a number between 0 and 10, where 0 means

no pain and 10 the worst possible pain.

4. Which word below best describes the **amount** of your overall breast pain? Check one.

___Mild

___Discomforting

___Distressing

___Horrible

___Excruciating

5. How does your breast pain change in time?

A. Which word or words would you use to describe the **pattern** of your breast pain?

___Continuous	___Rhythmic	___Brief
___Steady	___Periodic	___Momentary
___Constant	___Intermittent	___Transient

B. What kind of things **relieve** your breast pain?

C. What kind of things **increase** your breast pain?

6. Is your breast pain related to your **menstrual cycle**? ___Yes ___No

If yes:

Which day is your breast pain **worst**? Write a number between 0 and 28 where 28 indicates menstruation.

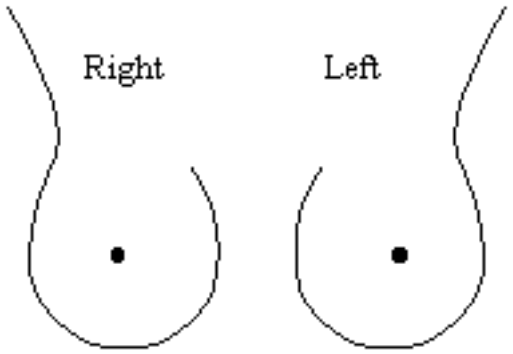
How long does your breast pain usually last? Write a number between 0 and 28 where 28 indicates menstruation.

7. How **often** does your breast pain occur? Check one.

___Every hour ___Every day ___Every week ___Every month

8. How **long** have you had your breast pain? ___Number of years ___Number of months

9. **Where**, exactly, does the pain occur? Please shade painful areas.



10. Has your breast pain affected your **work** schedule? ___Yes ___No

11. Has your breast pain affected your **sleep** pattern? ___Yes ___No

12. Has your breast pain affected your **sexual** activity? ___Yes ___No

13. Do you take **medications** to relieve your breast pain? ___Yes ___No

If yes, write the type of medications and doses that you take.

14. Do you have **other pains** besides breast pain? ___Yes ___No

If yes, write where?

how often?

Does it coincide with your breast pain? ___Yes ___No

Do you take any medications to relieve this pain? ___Yes ___No

If yes, write the type of medications and doses that you take.

15. If you have any comments regarding your breast pain that was not covered above please write them here: