Summit Health

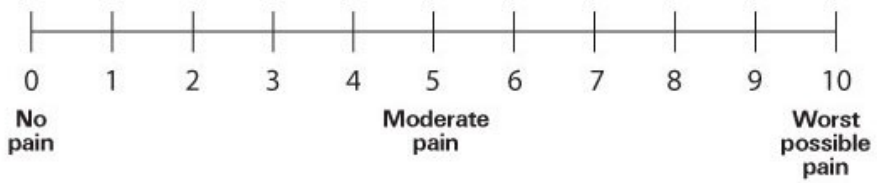
BREAST CARE

1. When did you **MOST RECENTLY** experience breast pain?

2. When did you **FIRST NOTICE** your breast pain?

3. How **OFTEN** do you experience breast pain?
   - ☐ Every hour
   - ☐ Every day
   - ☐ Every week
   - ☐ Every month

4. How would you rate your **OVERALL** breast pain?



5. Which of the following best describes the **SEVERITY** of your overall breast pain?
   - ☐ Mild
   - ☐ Discomforting
   - ☐ Distressing
   - ☐ Horrible
   - ☐ Excruciating

6. How would you describe the **QUALITY** of your breast pain? (Check all that apply)

	None	*Mild*	*Moderate*	*Severe*
Throbbing				
Shooting				
Stabbing				
Sharp				
Aching				
Heavy				
Tender				
Burning				
Gnawing				
Cramping				

7. How would you describe the **TIMING/PATTERN** of your breast pain?

- ☐ Continuous
- ☐ Constant
- ☐ Intermittent
- ☐ Rhythmic
- ☐ Brief
- ☐ Momentary
- ☐ Transient

8. Does anything **DECREASE/RELIEVE** your breast pain?

9. Does anything **INCREASE/WORSEN** your breast pain?

10. Is your breast pain related to your menstrual cycle?

11. Where is the pain? Please shade in the painful areas:

12. Does your breast pain impact any of the following areas of your life?

- ☐ Work
- ☐ Sleep
- ☐ Exercise
- ☐ Sexual activity

13. Do you have any **OTHER PAINS** besides breast pain?

14. If there is anything related to your breast pain not addressed above, please write them here: